University of Alberta

CONSTRUCTING THE MEANING OF "MENTAL DISTRESS": COPING STRATEGIES OF ELDERLY EAST INDIAN IMMIGRANT WOMEN IN ALBERTA

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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ABSTRACT

This thesis explores how non-institutionalized English-speaking elderly (aged 60-74) East Indian immigrant women "define" mental distress. To understand the perceived meaning of mental distress of elderly East Indian immigrant women, this multiple case study employs a symbolic interactionist framework. A purposive, snowball sample of twenty-one elderly East Indian immigrant women from India living in Edmonton, Alberta were interviewed face to face. Transcripts from semi-structured interviews were analyzed using a thematic analysis.

The findings suggest that East Indian immigrant women not only think that mental distress has negative effects on a person's emotional, mental and physical self but also think that this negative experience can be prevented or minimized. The dominant theme for managing mental distress among the participants was "maximizing control over one's inner self." This management paradigm revolved around the Indian psychology of "staying busy," which includes five activities: engagement in family or household affairs (*grhasta*), religion and religious duties (*dharma*), acceptance of fate and action (*karma*), material well-being (*artha*) and living alone (*sannyasin*). Moreover, the integration of Indian tradition and spirituality/faith to cope with mental distress and enhance their living in old age has led the participants to describe their traditional culture as a "moral medicine."

The thesis concludes with implications and limitations, and suggests that this analysis of social construction of mental distress has offered a conceptual paradigm for future ethnogerontological health research which will be beneficial to professional and non-professional caregivers.

DEDICATION

To Mrs. Gita Das and Dr. J. P. Das.

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TABLE OF CONTENTS

CHAPTER ONE
INTRODUCTION 1
- Purpose of the Research 5
- Research Questions 5
- Organization of the Thesis 6

CHAPTER TWO
DEMOGRAPHICS: AGING CANADIAN MULTICULTURAL POPULATIONS 8
- A Rapidly Growing Diverse Population in Multicultural Canada 8
- Cultural History of East Indian Immigrant Women in Canada 13

CHAPTER THREE
AGING ELDERLY VISIBLE MINORITIES, WOMEN & MENTAL HEALTH 25
- Explanations about Mental Distress and Healing 26
- Symbolic Interactional Approach to Knowledge Construction 62

CHAPTER FOUR
THE PATH FOR UNDERSTANDING MENTAL DISTRESS AND HEALING 67
- Research Design 68
- Data Collection Strategies Utilized 78
- Data Analysis Strategy 84
- Characteristics of the Research Participants 88

CHAPTER FIVE
INTERPRETING AND EXPLAINING MENTAL DISTRESS 91
- Perceived Meaning of Mental Distress 91
- Perceived Causes of Mental Distress 98
- Perceived Consequences of Mental Distress 134
- Summary 140

CHAPTER SIX
COPING STRATEGIES OF MENTAL DISTRESS 142
- The Indian-Canadian way of Coping with the Threat of Mental Distress 143

CHAPTER SEVEN
CONCLUSION, IMPLICATIONS AND LIMITATIONS 193
- Implications for Caregivers, Policy Planners and Future Research 196

REFERENCES 200

APPENDICES 232

LIST OF TABLES

Table 1. Sample Demographic Characteristics, Alberta, Canada, 2001 90

Table 2. The Perceived Unprepared Events in the Family/Household and Psychological Experiences Recognized by the EIIW living in Alberta, 2000 - 2001 110

LIST OF FIGURES

Fig. 1. Sashti Purthi ceremony performed in traditional style in Edmonton 16

Fig. 2. Hindu priest performing the traditional Indian ritual in Edmonton..... 16

Fig. 3. Research Method 83

Fig. 4. Map of India showing EIIW participants place of origin 89

Fig. 5. A Pictorial Description of the Mental Distress..... 92

Fig. 6. Model of Perceived Causes of Mental Distress of Aging EIIW 99

Fig. 7. Perceived Consequences of Mental Distress of Aging EIIW 135

Fig. 8. Elderly EIIW Coping Paradigm of "Staying Busy"..... 147

Fig. 9. A Sikh elderly immigrant woman participating in prayer at home..... 170

Fig. 10. A Hindu elderly immigrant woman participating in prayer at home..... 170

ABBREVIATIONS USED IN THE THESIS

CAD	Cardiovascular Disease
CPP	Canadian Pension Plan
EI	East Indian
EII	East Indian Immigrant
EIIM	East Indian Immigrant Men
EIIW	East Indian Immigrant Women
FEP	Federal Employee Plan
GIS	Guaranteed Income Supplement
OAS	Old Age Security
PCG	Professional Caregiver
PTSD	Posttraumatic Stress Disorder
VM	Visible Minority
VMI	Visible Minority Immigrant
VMIW	Visible Minority Immigrant Women
VMM	Visible Minority Men
VMW	Visible Minority Women

CHAPTER ONE

INTRODUCTION

> Duality is the fundamental cause of suffering. But when the entire field of life is dual in nature, how can life be free from suffering? This has always been a serious problem of metaphysical and indeed of practical life as well. The solution lies in the infusion into the field of duality of a non-dual element which blesses man's life with a status unaffected by suffering, even while he remains in the field where suffering is possible. This will be appreciated as the discourse advances. (Yogi, 1967, p. 52)

Everyone experiences emotional distress, a common psychological problem[1], many times in life. Such "disrupting stress" (Selye, 1974) is linked to negative reactions to unpleasant social situations or age-related life crises. It also is drawn from physiological, interactional or structural states (Schmitt & Schmitt, 1996). For most people, however, this intrusive emotion is usually conceived as *mental distress* and as a normal part of life. The western system of *Bio-medicine*[2] cautions that, although mental distress may not be life threatening, in the absence of compensatory positive experiences or early diagnosis it places a person at risk for major depression, the "silent illness" (The Economist, 1998/99, p. 113), or death (Stenchever, 1996).

Understanding the subjective meaning of mental distress among laypersons has become an important health issue for professional caregivers (PCGs) and researchers across the globe[3]. It is also crucial to understand how people overcome adversity (Heidrich & Ryff, 1996; Sperry, 1996; Gutmann, 1997; Schreiber et al., 2000; Auger & Tedford-Litle, 2002). One daunting challenge for PCGs is to explore how high-risk populations such as the elderly (aged 60+) cope with the perception of mental distress in

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[1] The terms emotional distress and psychological distress are used synonymously.

[2] The most outstanding characteristic of Biomedicine or the Bio-Medical system is fixation on problems that are caused by physical pathology. For instance, health problems such as epilepsy, schizophrenia, dementia and delirium seem to have clear and immediate biological cause. The physician, psychiatrist in particular, is qualified and trained, and in these cases most appropriate for correcting the disease. Treatments for disease or illness most often take place under the guidance of a physician in a clinic, hospital or office (Cockerham, 2000).

[3] In 1999, the World Health Organization reported, "There are 330 million people suffering in the world from depression, but it is estimated that 90% of these persons will not get adequate treatment" (The Economist, 1998/99, 113).

a rapidly changing world. The aging of the world population in the next two decades[4] will contribute to the growing incidence of mental distress and depression (Walker, 1996; Horwitz & Uttaro, 1998; Chappell et al., 2003).

This association between old age and mental distress (Tausig et al., 1999) has produced several hypotheses (Butler et al., 1998). One is that major life changes in old age are causally linked to the onset of psychological distress and other mental health problems: "Thinking about old age…most commonly elicits a checklist of unpleasant or distressing events. These include changes in health and physical functioning, widowhood, death of friends and family members, perhaps a change in residence or loss of income" (Heidrich & Ryff, 1996, p. 73). The elderly tend to deny symptoms of mental distress more often than the young (Wehry, 1995), probably because of their limited understanding of mental distress, sense of shame because of social stigma (Butler et al., 1998), fear, denial, or perceptions about self-control over their physical and emotional selves (Antai-Ontong, 1997).

Whatever the reason for their denial, epidemiological findings suggest that older women especially are at high risk for mental distress (Bonita, 1998; Louie, 1998; Padgett et al., 1998; Cattell, 2000; Richardson, 2001; Auger & Tedford-Litle, 2002; Chappell et al., 2003). Demographically, women have longer life expectancy than men and are more likely to experience insecurity, lack of confidence and self-esteem (Olshansky, 2000), widowhood, retirement, poverty, disease and disability (Kabache & Bertiere, 1998; Phillips, 2000; Lindsay, 2000; Chambers, 2000). Such factors lead to greater stress and hardship in older women's lives, and to more suicide attempts than among older men (Cockerham, 2000).

Gaps remain in our understanding of mental distress and its consequences for older South Asian[5] immigrant women[6] in western societies (Ebrahim et al., 1991; Burr,

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[4] Novak & Campbell (2001) indicate that the present global elderly population (aged 60 years and over) of approximately 9.2 % is expected to reach 15.7 % in 2030.

[5] According to Statistics Canada, South Asians are people who identify their ethnic/cultural origin or last permanent residence as India, Pakistan, Bangladesh, Bhutan, Nepal or Sri Lanka.

[6] The life expectancy of immigrants, especially from non-European countries, is greater than for the Canadian-born, and immigrant women have longer life expectancy than men (D'Arcy, 1998). Thus, the recognition of mental distress in these older women will become increasingly important.

1992; Bhatnagar & Frank, 1997). Most cross-cultural studies on psychological problems have focused on comparison of non-white and white populations (John et al., 1997; Ganguli et al., 2000); refugees from war torn countries (Bernier, 1992; Ying et al., 1997; Giles, 1999); economically challenged groups (Cross, 1995; Chung & Bemak, 1996); clinical populations (Bhui et al., 1995; Ananthanaryanan, 1996; Silveira & Ebrahim, 1998; Livingston et al., 2003); new immigrants (Dossa, 1994; Berry, 1997); and young and middle aged non-white women (Naidoo, 1992; Cross, 1995; Bhattacharjee, 1997; Louie, 1998; Schreiber et al., 1998, 2000). Western researchers, particularly in North America, have paid little attention (Burr, 1992; Mehta, 1998) to studying the mental distress of elderly East Indian immigrant women (EIIW), the largest subgroup of South Asian women, who emigrated from India (Citizenship & Immigration Canada, 1996b) and are aging abroad. A few immigration and acculturation studies, however, reveal that some older EIIW[7] suffer from age- and isolation-related psychological problems and are at high risk for neglect, family problems (Desai, 1992), singlehood (Burr, 1992), poverty (George, 1992) and severe depression (Williams & Hunt, 1997).

Studies on the relationship between life events, personal characteristics, cultural factors and psychology are central to research in cross-cultural gerontology (Gutmann, 1997; Chappell et al., 2003) and women's health. Such research may improve our understanding of how EIIW, as a group, manage to avoid mental distress and maintain identity when faced with the challenges of old age. More importantly, such research will document the role of perception, life experience and cultural knowledge in the development of mental distress[8] among non-white and non-western immigrant women. Eisenbruch (1991) contends that culture, when an ascribed characteristic, can cause immigrants negative emotions during chronically stressful life events, particularly individuals with high ethnic identity.

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[7] Kumar & Stanley (1996) and Yadava et al. (1997) found that economic insecurity, loneliness, isolation, neglect, decline in authority and adjustment to others cause emotional and psychological distress in Indian women. In contrast, Mehta (1998) and Hooyman & Kiyak (2002) emphasized that the number of EII people are small for conducting meaningful scientific studies, while Burr (1992) described EIIW as a "model minority" with a few emotional problems.

[8] See Sindzingre (1995), Bhui (1997), Chiu (2000) and Davis (2000) for details.

Culture can be a significant predictor of psychological distress (Dresseler, 1990; Helman, 2000; Cockerham, 2000) when psychological distress is viewed as a malignant social disease. Sensing social stigma, East Indian scholars, community leaders and feminists have been reluctant to focus on mental health issues in their community. Instead, researchers have been concerned with more basic sources of acculturative stress among immigrants: language barriers (Mehta, 1998), skills training and marginalization (Majumdar et al., 1999), discrimination and cultural orientation (Naidoo, 1985; Bagely, 1992; Dossa, 1994). They consider these not as individual issues but rather as collective political issues, in order to reduce negative publicity about their communities (True, 1995; Abraham, 2000).

In addition, East Indian immigrants (EIIs) tend to link the word *mental* with "mental disorder" (Chakraborty, 1990), "hysterical illness" (Kakar, 1982), and "madness" (Shirali, 1998), thus further hampering community-based research. Their negative attitude toward mental health problems has hindered the establishing of an accurate indicator of health needs and the provision of appropriate community-based health care services that are cost-effective in terms of economic, cultural, emotional and physical health. It is vital to change this negative view – and corresponding medicophobia – and to develop a more comprehensive understanding of mental distress among the older EIIW.

The few studies available on EIIs in general indicate that these people under-utilize biomedical mental health services for diagnostic and therapeutic purposes (Gupta, 1991; Raport Research, 1996; Hutchinson & Gilvarry, 1998; Ananthanarayan & Cochrane, 1999). These studies provide valuable insight into EIIs' differential patterns of health service utilization; however, the findings seem to be conceptualized and operationalized from the perspective of biomedicine and not culture (Bhui et al., 1995). To date, no studies have explored how non-institutionalized older EIIW conceptualize and cope with common mental problems in western societies.

To advance our understanding of cross-cultural mental health research in gerontology, research must examine the realities of ordinary elderly EIIW facing old age in Canada. As stated earlier, "[These women's] faces and their voices, their needs and

their stresses, their strengths and their sickness, their anger and their losses are unseen and unheard" (Shirali, 1998, p. 66). Specifically, information is needed on how they think (Douglas, 1986), perceive (Charmaz, 1990), and cope (Reutter, 1991) with anxiety, loneliness, worthlessness, grief and depression, five common psychological indicators of mental distress.

I. Purpose of this Research

The purpose of this study is to explore how elderly EIIW from India residing in the metropolitan area of Edmonton, Alberta, Canada define and cope with mental distress in their everyday lives. An excellent way to explore this topic is through the lens of the participants. Such a subjective analysis requires a symbolic interactionist paradigm, for several reasons. First, this theoretical framework presumes that human beings define an issue according to the meaning they attach to it (Blumer, 1969). Second, human thought, perception and behavior change according to the influence of others or the social situation (Charon, 1992). Third, symbolic interactionism considers interaction and interpretation processes to be central to describing why and how and individuals attach meaning to their social situation. Finally, this framework allows the researcher to emphasize different parts of the theory (Craib, 1992) and to incorporate various approaches in order to explain the process and politics of knowledge construction (Ritzer, 2000).

II. Research Questions

In order to describe how EIIW construct the meaning of mental distress in old age and manage mental distress within a changing society, this study uses a qualitative research approach. Qualitative research methodology allows systematic exploration of the following concerns:

1. How elderly EIIWs individually and collectively construct notions of how common anxiety, grief, loneliness, worthlessness and depression are different from mental distress
2. How these individuals explain specific categories of emotional problems
3. Whether changing life events place EIIW at risk of experiencing mental distress, and if so, what types of events have this effect

4. How EIIW elders describe and cope with emotional problems to avoid or prevent mental distress
5. What factors hinder or enhance their coping efforts
6. How elderly EIIW's perceptions and experiences affect their use of health services and alternative health care for mental wellness over time, and why

This methodology (Berg, 1998; Strauss & Corbin, 1990; Streubert & Carpenter, 1999; Chappell et al., 2003) allows me to develop inductive theory about complex social processes. It also reveals the critical space that age, gender and culture occupy, especially in terms of the causes, consequences and coping strategies of mental distress.

III. Organization of the Thesis

Qualitative research traditionally uses a holistic approach to study the process of knowledge construction of a cultural group, social organization or institution. In the context of health and wellness, this model encourages individuals to explain their knowledge, perception and experience of mental health, the types of prevention they believe in, and to whom they turn when suffering emotional pain. As Douglas (1995) states, "A person's experiences and his/her lay conceptions of sickness cannot be separated from macro-social phenomena" (p. 22). The holistic approach allows the researcher not only to understand what mental distress means to individuals but also to reconceptualize the social (macro) and psychological (micro) forces that shape the perception and experience of mental distress for numerous and different individuals. This study of the EIIW's mental distress construction subscribes to the holistic approach, as reflected in the organization of chapters.

Chapter Two provides a brief demographic analysis of the rising numbers of aging visible minorities in Canada and focuses on the cultural history of EIIW in Canada. Chapter Three contextualizes the study theoretically, discussing a range of social science models and traditions in the study of elderly South Asian women's mental health. Chapter Four outlines the methods used during four months of field research in Edmonton, Alberta that formed the empirical focus of the study. It also reviews the computer techniques used for data analysis.

The discussion shifts to subjective analysis of mental distress in the final two chapters. Chapter Five investigates the personal and cultural meanings of common emotional problems and mental distress from the older EIIW's perspective. It then illustrates the interaction between past and present biological, sociocultural, psychological and emotional conditions and the unpredictable future in the construction of EIIW's perception of mental distress in Canada, and consequently the production of mental distress theory.

Chapter Six analyzes the knowledge and experience evidenced in the individual life stories of older EIIW, in order to examine their coping strategies from the onset of mental distress. This chapter explains how aged EIIW imbued in traditional Indian ideology and present culture, and in an ethic of personal constraint, continue to use "Indian" culture as moral medicine to seek control over their lives in a high-risk, aging, "anti-depressant" society. A brief concluding summary follows.

CHAPTER TWO

DEMOGRAPHICS: AGING CANADIAN MULTICULTURAL POPULATIONS AND THE CULTURAL BACKGROUND OF ELDERLY EAST INDIAN WOMEN IN CANADA

This chapter's demographic and cultural review of elderly EIIW is divided into two major sections. The first gives a brief demographic description of Canada's development of multicultural policy[9] and programs. These proximate forces seem to have contributed to the rise in Canada's aging EIIW population, the sample group under study. Little seems to be known about the association between EIIW's aging in a foreign land and mental distress. The second section describes the cultural history of elderly EII, women in particular. This section reviews key East Indian feminine characteristics, values and traditions, which most elderly EIIW participants use extensively along with other coping resources to avoid mental distress in old age[10].

I. A Rapidly Growing Diverse Population in Multicultural Canada

Canada is not only experiencing the "aging"[11] of its population but also witnessing a change in the ethnic, cultural and gender composition of older populations. A main contributory factor in the changing ethnic and cultural composition of Canada is the development of a colour-blind, economically- and kinship- oriented immigration policy in the 1970s. The *Immigration Act* of 1976 has not only kept Canada economically and technologically progressive (McVey & Kalbach, 1995) in the current global market, it has also "multi-coloured" the population structure (see Appendix A). Since 1976, directed efforts have been made at the policy level to endorse programmes and services which are culturally, sexually, racially and linguistically sensitive and responsive, and free of discrimination and prejudice (Masi, 1993; Acharya, 1996; Schreiber et al., 1998; McDaniel, 2001; Auger & Tedford-Litle, 2002). However, a review of the development stages of Canadian multicultural policy and programmes reveals the challenges that remain in a sociological perspective on elderly EIIW and mental distress.

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[9] Aboriginal peoples were the first non-white group contributing to multiculturalism in Canada.

[10] See Chapter Six for further details.

[11] The most common definition is the percentage of the population aged 60 and over. A country is called "aged" when 10% of its population belongs to the 60+ age group (Novak & Campbell, 2001).

A. The Development of Multicultural Policy and Programmes

The gradual shift in Canadian immigration patterns from 1961 to 2001 is evident from Appendix A. In addition to the demographic transition, the triumphs, achievements and limitations of multicultural policy and programmes are explored under three broad historical periods: 1) pre-multicultural, 2) multicultural, and 3) post-multicultural.

The Pre-Multicultural Period (1961-1970)

The 1960s can be considered the pre-multicultural period of immigration, during which the immigrant population continued to be mostly Europeans, primarily North Europeans (Driedger & Halli, 2000). Nevertheless, a large proportion of immigrants (27.9%) came from southern European countries such as Italy, Hungary, Portugal and Greece. At this time no extensive multicultural policy and programmes were in place for these people (Indra, 1987; Ng, 1988; Driedger & Halli, 2000). Research on gender, culture and ethnicity was limited until the 1970s (Naidoo, 1976, 1985; Buchignani, 1994; Driedger, 1996), as in other areas of study. For instance, ethnopsychiatry, the study of mental health of ethnic and racial minorities, began in Canada only in the 1980s (Chan, 1983; Beiser 1984; Kim, 1987; Chan & Indra, 1987), and focused on aging women only in the 1990s (Bernard et al., 2000; Auger & Tedford-Litle, 2002). However, elderly visible minority women have not been central in these studies; their experience has not been a high priority for sociological and feminist studies of psychological distress.

The Multicultural Period (1971-1980)

During the 1970s, the multicultural period, an influx of immigrants from Asian (33.4%) and African (5.8%) countries as well as Europe arrived in Canada. This immigration pattern resulted from the 1967 introduction of the point system for assessing admissibility of immigrants (Knowles, 1992; Burnet & Palmer, 1988). Subsequently, immigrants were no longer selected based on ethnic criteria (Ramcharan, 1992), culture (Kanungo, 1992), or nationality (D'Costa, 1992). Liberalisation of Canada's immigration policy and the political actions of western Canadian pioneers, including Aboriginal leaders, led in 1971 to the establishment of a multicultural policy within the framework of bilingualism (Burnet & Palmer, 1988). This policy has proved effective for Canada for two reasons: it assures the cultural freedom of all Canadians (Abu-Laban, 1994, p. 102),

and it recognises every Canadian's role in forging a Canadian identity (Boyd & Vickers, 2000)[12]. This formalized multicultural policy set the stage for later extensive cross-cultural health research, including mental health research, on ethnic visible minority populations.

During the 1970s, however, sociological research topics focused primarily on the process of adaptation, integration and acculturation of non-dominant[13] immigrants in Canada (Buchignani & Indra, 1985). Studies addressed issues of adjustment, change, and conflict in the culture of new immigrants. Other research involved studies of Canadians' attitudes towards different ethnic and cultural groups (Berry et al., 1976; Naidoo, 1976, 1985). Despite these cross-cultural exploratory studies, the mental health issues of aging immigrants and refugees tended to be overlooked in many of the health policy and practice discussions. Masi, Mensah and McLeod (1993) provide five reasons for this lack of attention to the health concerns of immigrants and refugees: cost of health care and of change; lack of political and community control of health policy, institutions and organizations; resistance by the health professions; ineffectiveness of health ministries, their political leaders and bureaucracies; and the domination of health by science and technology (p. 3). This systemic discriminatory attitude towards visible minority immigrants may have endured because of inadequate population size. The constraints on research related to elderly visible minority immigrant women's mental health have since changed with population statistics and the Multicultural Act of 1988.

The Post-Multicultural Period (1981-present)

From 1981 to the present can be characterised as the post-multicultural period, when domestic manpower and family reunification criteria became the major points of Canada's immigration policy. During this period, Asia surpassed Europe as the top source of immigration to Canada. The Asian proportions increased from 33.4% in 1971-80, to 47.2% in 1981-1990, and then to 58.2% in 1991-2001 (see Appendix A). The

[12] In addition to the establishment of multicultural policies in 1971, the Canadian Human Rights Act was passed in 1977; in the same year the Citizenship Act came into effect.

[13] Non-dominant immigrants were non-Europeans and non-white in physical characteristics.

Multiculturalism Act became law in 1988[14] and further grounded the multicultural policies of the 1970s and early 1980s.

In the past fifty years, Canada's rapidly evolving multicultural, multiethnic and pluralistic society has affected every aspect of Canadians' lives. The sociological and social psychological study of ethnicity, culture, gender and health has blossomed. In theory and research, the promise has begun to be filled. For instance, there have been extensive studies related to immigration and relocation stress (Kim, 1987; Beiser, 1988; Falk, 1993; Noh & Avison, 1996; Majumdar et al., 1999), intergenerational relations (Wong & Reker, 1985; Driedger & Chappell, 1987; Hall, 1993; Ujimoto 1995; Buchignani & Armstrong-Esther, 1999), gendered violence within immigrant families (Agnew, 1996; Negi, 1996; Indra, 1999; Gilad, 1999; Das, 1999), settlement patterns of different ethnic, racial and cultural immigrant groups and its relationship to social stress (Berry & Kim, 1988; Berry, 1990; Avison & Turner, 1988; Danesi, 1993; Bassi, 1995; Ward, 1997; Acharya, 1998; Crawley, 1999), cross-cultural health problems and practices (Waxler-Morrison et al., 1990; Singh & Kinsey, 1993; Dillmann et al., 1993; Kulig, 1994; Gelfand, 1994; Denton et al., 1999; Schreiber et al., 2000), and ethnocultural minorities and health services (Dossa, 1990; Peters, 1993; Lo & Lee, 1993; Auger, 1993; Saldov & Chow, 1994; Raport Report, 1996; Ball, 1998).

Furthermore, in the 1990s, a few studies concentrated on the contributions of visible minority immigrants to Canadian society (Burnet & Palmer, 1988; Kanungo, 1992; Velshi, 1992; Kobayashi & Rosenberg, 1993), their labour force performance (Ralston, 1992; Jamal, 1998; Samy, 1999; Basran & Zong, 1998; Basran, 1999; Badets & Howatson-Leo, 1999; Lindsey, 2000; Chard, 2000), prejudice and discrimination (Driedger & Mezoff, 1981; Bannerji, 1991; Boyd, 1992; Bolaria & Bolaria, 1994; Das Gupta, 1994, 1996; Giri, 1998), and more recently poverty (George, 1992; Bassavrajappa, 1999; Kazemipur & Halli, 2000).

New data and analyses, theories, research paradigms, and policy frameworks have emerged, and are emerging, to advance sociological knowledge about immigrants and

[14] In 1982 the Canadian Charter of Rights and Freedoms was introduced. In 1986, the Employment Equity Act was established. Between the 1980s and early 1990s the Department of Multiculturalism and Citizenship was created.

multicultural policy and programmes. However, little research is available on aging Canadian visible minority immigrant women's subjective understanding of mental health issues. There is little to guide PCGs and policy makers in caring for these women. For example, Canadian ethnogerontologists performing sociopsychological research have mostly examined the relationship between ethnicity and social support (Novak & Campbell, 2001), leaving gaps related to the personal meaning of mental distress, the cultural context, and the measures taken to maintain emotional wellbeing by older non-western visible minority women such as the EIIW.

It is clear that demographically the visible minority population has made significant strides (Statistics Canada, 1991, 1994, 1997a, 1999, 2000, 2001, 2003a). As a group, in 2001 their population size had more than doubled (13.4%) from 6.3% in 1986; they are expected to number 20% of the total Canadian population by 2016 (Driedger & Halli, 2000; Statistics Canada, 2003b). In absolute numbers, by 2016 the number of visible minority Canadians[15] is projected to increase to 7.1 million from 2.7 million in 1991 (Isajiw, 1999). This shift in immigration trend is likely to influence not only the Canadian aging and ethnic composition, but also the sociocultural, economic, language, transportation, leisure activities, living arrangements, physical and mental health factors that are critical for "successful" aging among the elderly (Thomas & Chambers, 1989; Marshall, 1996; Auger & Tedford-Litle, 2002). Therefore, consideration of elderly EIIW's thoughts and feelings about mental distress is warranted and timely.

This chapter concludes by reviewing the cultural history of elderly EIIW from India, in order to provide greater critical insight into the EIIW's construction of the concept of mental distress and their risk management style, discussed in later chapters. This section describes two key cultural resources of Indian tradition: the Indian social theory of duty, and household-oriented practices. These resources provide Indian women with a distinct Indian national identity and personal power, helping them to cope with mental distress in later life.

[15] This category includes both Canadian-born and immigrants.

II. Cultural History of East Indian Immigrant Women in Canada

A. Traditional Indian Culture

The elderly EIIW sampled in this study originate from India. According to the 2001 Indian Census, India has more than one billion diverse[16] people. Pillai (1985), an Indian cultural anthropologist using an evolutionary-historical approach, showed how Indian society during its "social evolution" had three distinct types of cultures: the continuation of traditional India where pre-industrial agrarian culture was practiced; transitional India, in transition from agrarian to industrial and from monarchical and colonialist to democratic; and finally, industrialized India, which led to the development of metropolitan communities (p. 210).

Despite these changes in contemporary India, the literary scholars and people of India still explicate many of their perceptions and experiences of social issues in terms of powerful Indian cultural beliefs (Kakar, 1982; Kanbargi, 1985; Roy, 1985; Soman, 1998; Davar, 1999) that are built on Hindu[17] traditions (Macionis & Gerber, 2002). The main characteristic of traditional Indian society is its subsistence orientation, based on an agrarian land economy. In this type of agriculture-based society and culture, joint family households[18], arranged marriages[19] and dominant religious practices are important social institutions for individuals' existence and security (Pillai, 1985; Yadava et al., 1997).

In a study of social aging in a middle-class neighborhood of Delhi, Willigen et al. (1995) found that the urbanized participants' interpretation of social aging was grounded more in traditional Indian ideology than in ancient religious Hindu texts[20]. Although the

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[16] The concept of diversity refers to differences based on age, sex, religion, language, caste, class, region, ethnicity and culture. In India, diversity not only includes the above categories, but every state of India is separate based on linguistic identity and practiced regional culture.

[17] The term Hindu refers to the place, people and their way of life. The Hindu social system has its roots in agrarian culture.

[18] Gangrade (1988) states, "The main feature of the traditional joint family system is that it is three-generational in depth, its members live under the same roof, and property…is shared by all" (p. 27). Similarly, Devadoss (1979) describes joint family as a co-operative institution where every member does his duty under the guidance of the eldest members.

[19] Marriage arranged by family, instead of the young woman or man. It is the most prestigious and expensive family ceremony (Dumont, 1980).

[20] For an in-depth analysis of India's Caste System and its organizing principles, see Dumont (1980).

participants lived in an urban culture and belonged to different religious, linguistic and ethnic communities, the four concepts of the Indian social tradition played a vital role in their everyday lives. The four concepts are religious-moral duty (dharma), worldly affairs of an economic nature (artha), pursuit of pleasure in the world and social duty (karma), and rest in old age, the ultimate escape cycle (moksha). These doctrines of Indian tradition, according to Sudhir Kakar (1982), "permeate the everyday life of ordinary people giving structure and meaning … This type of thinking is so much in a Hindu's bones, that a person may not be aware of its influence" (p. 15). As result, these concepts help many to withstand the challenges of a rapidly globalized world and changes in life course. From an Indian feminist constructivist perspective, Davar (1999) argues that these doctrines not only gender household practices, but they help many women to sustain their social support systems and their self identity. More importantly, a collective group identity develops to prevent or resolve any life course challenges (Shirali, 1998; Butalia, 2002).

Micro level analysis of traditional Indian cultural identity shows that, for most elderly people in India, human resources including the family, children, grandchildren, friends, and other kin links are central for social and personal security. Mahajan (1992) states, "They are the traditional building blocks of traditional social structure in India" (p. 415). Therefore, many believe that so long as traditional principles govern their way of life, the Indian joint family system will withstand the challenges of modernity (Devadoss, 1979) and globalization. Willigen et al. (1996) support these assertions in their social network study of urban elders in India. However, they caution, that although the joint household is important, not all elders or both sex groups benefit in every aspect of life from this cultural tradition. Willigen et al. have identified a significant correlation between network size and health status of elderly women in India. They further contend that, because of the patrilineal orientation of the joint family household, older women seem to have limited control over household resources and activities. The age and gender bias seems to make these women vulnerable to social isolation even in a joint household setting.

A review of aging policy research by the Indian government shows the continuation of traditional Indian cultural identity discourse in contemporary India. The

literature reveals that the contemporary Indian government is still not economically, politically or socially committed to its aging population (Yadava et al., 1997). Instead, the Government of India plays an important role in maintaining traditional Indian ideology (Pillai, 1985; Kanbargi, 1985) in response to all the problems of the aged (Pai, 1988; Srivastava, 1994). As a result, the national identity of India is socially constructed around the household, of which marriage is an important component (Devodass, 1979). This national identity practice is echoed by Biswas (1994): "In India, in spite of modernizing forces operating due to the faster pace of industrialization, the important role of traditional culture is still in vogue in the management of the cares of the aged" (p. 111).

The hegemony of traditional Indian cultural ideology is further elaborated in the following discussion of the demographic characteristics, family identity and caregiving issues of elderly persons in contemporary Indian society.

B. Demographic Characteristics: Individual and Household

India is considered a youthful country,[21] but there is an increase in the number of old people[22]. Mahadevan et al. (1992) found that, in 1981, the elderly population of India ranked fourth in size among the countries of the world, although the proportion of elderly persons is relatively small (Behera & Parida, 1991).This slow growth in the aging population confirms that, although India's age structure is changing, it continues to have a greater bias towards young people.

Many elders maintain their symbolic status as head of the household[23] because of their economic position, acquired knowledge, and varied life experiences (Mahajan, 1992). Despite urbanization, some communities in southern India still show traditional respect to elderly men who reach the age of 60 by performing a religious ceremony (Upadhya, 1994) called *Sashti Purthi* (see Figure 1 and 2).

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[21] According to international demographic standards, a country is considered young when less than 4% of total population belongs to age 65 and over, and youthful, mature or aged when, 4-6%, 7-9% and 10% of its population belong to these age categories, respectively (Novak, 1997).

[22] Although international convention accepts 65 years as the cut-off point for being considered old, in India, the Indian Census has used 60 years as the line of separation (Nayar, 1994).

[23] According to the 1991 Census, 91.9% of households had a male head, versus 8.1% with a female head.

Figure 1. Sashti Purthi ceremony performed in traditional style in Edmonton.

Figure 2. Hindu priest performing traditional Indian ritual in Edmonton.

The Sashti Purthi ceremony is performed on a man's 60th birthday. Traditional Indian society used to sanction retirement of a man aged 60 from his duty as a householder, at which point the duty of the son to look after his aging parents began (Mahajan, 1992). The ceremony represented the transfer of power from father to son in a

patrilineal household, although the aging father continued to remain the head of the family (Reddy & Rani, 1994), spending more time in spiritual exploration (Devadoss, 1979). The family's socially constructed traditional ritual observance to honor the male elders for their long years of service, called gerontophilia in the West (Barrow, 1996), seems to have influenced contemporary Indian psychocultural thinking (Davar, 1999), particularly concerning "Indianness." Consequently, the traditional ritual for aged Indian Hindu men has broadened to include elderly women (Reddy & Rani, 1994), thus locating both elderly parents within the conceptual Indian cultural tradition. Many urbanized Indian families both in India (Biswas, 1994) and abroad (Hartel, 1995) now celebrate the 60th birthday, reflecting the expansion of Indian traditional ideology and, more importantly, the celebration of extended longevity in the face of normative and non-normative life challenges[24].

Not all elderly Indians have a long life; in India, many women do not live long enough to experience this traditional recognition. The sex ratio of the old in the total population of India differs from that in industrialized countries in the world, where women outlive men (Organization for Economic Co-Operation and Development, 1996; Bonita, 1998; Chappell et al., 2003). In India, the sex ratio is biased in favour of men. For instance, in 1980, men made up 51.7% and women 48.3% of persons aged 60 or over[25] (Dandekar, 1996). A similar pattern was evident in 1991 and 2001(Census of India, 2003).

Nevertheless, the percentage of widows is much higher than the percentage of widowers in this age group. The age gap between husband and wife is one of the most important factors for widowhood (Chakraborty, 1990; Manna & Chakraborty, 1994), and many women experience widowhood for a long period of time. Moreover, older men are

[24] Until 1970, India had high fertility and mortality rates from infectious diseases and famines. The average life expectancy of India's population did not reach 60 years until the late 1990s (Bonita, 1998).

[25] Although the 1991 Census of India illustrates an overall improvement in the life expectancy trend based on sex (life expectancy at birth for both male and female is 60 years), comparison by state reveals differences in this trend. In Uttar Pradesh, between 1981 and 1988 the life expectancy for females was 49.6 years, versus 52.3 years for males. In contrast, women in Kerala are expected to live on an average 72.2 years and men 65.9 years (Census of India, 1998). The life expectancy differential rate within India is associated primarily with level of education and economic status (Naidu & Sujatha, 1995). Poor nutrition, inadequate access to health care, and inadequate care by family members is thought to cause the adverse sex ratio of elderly women (Mahadevan et al., 1992; Dandekar, 1996; Bonita, 1998).

more likely to remarry, thus contributing to the high percentage of older widows (Bose, 1988) with a low socioeconomic status[26] (Dandekar, 1996). Most widows live within joint families (Manna & Chakraborty, 1994) and receive little attention (Davar, 1999). The absence of a spouse and the loss of status bring feelings of loneliness, deprivation, helplessness and distress for many elderly widows (Behera & Parida, 1991).

Despite some government-assisted programs, because of traditional negativism towards widows in Indian society, even in the 1990s the position of widows has not changed much (Sandhya, 1994). Some Indian feminists describe widowhood as a curse for women (Guha, 1992; Sandhya, 1994). To strengthen their emotional health, many heighten their dedication to long hours of piety and prayer at home (Pillai, 1985), and most have special prayer rooms in the house. They listen to the names of God at leisure times, and many live in or regularly visit religious institutions (Sandhya, 1994; Willigen et al., 1995). This religiosity gives solace and relief to many in times of distress (Chakraborty, 1990) and misery (Pillai, 1985). Sandhya (1994) contends that religiosity functions like opium for most Indian women who are experiencing severe internal pain from societal sanctions. However, Davar (1999) argues from a feminist psychoanalyst perspective that, "In a gender oppressive Indian society, religious beliefs give greater levels of satisfaction with life, bring personal happiness, and fewer negative psycho-social consequences of traumatic life events" (p. 129). Religious devotion empowers many elderly women to deal with problematic social conditions and maintain their spiritual status ("the God-Atman" through renunciation of egoism) in the in-built traditional hierarchy (Devadoss, 1979).

Most elders reside in rural areas, despite an increase in the urban population (Reddy, 1995; Gurumurty, 1998; Census of India, 2003). Many are engaged in agricultural and allied sectors of service (Nayar, 1994) where the concept of retirement is uncommon (Kanbargi, 1985). One can work as long as one is capable of working, because one's labor helps the family to move upward in the social strata (Pillai, 1985).

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[26] According to Indian Labor Force statistics, fewer women in India work for formal sectors entitling themselves to retirement benefits. In 1991, only 22.2% of the total workers population was female (Census of India, 1998). The majority of EIW have no other savings or personal property for economic support than the family, the only socio-legal institution (Devadoss, 1979) available to most people in Indian society.

Most important, the longer the man works, the longer he remains head of the household; his work also enhances the socioeconomic status of family members (Willigen et al., 1996; Yadava et al., 1997).

In this type of employment in India, termination of aged workers from the labor force is not dependent on "social aging"[27] (McDaniel, 1986) but on "functional aging." Functional aging occurs when a person becomes functionally disabled, cannot perform daily activities (Caffrey, 1992) and stops working for pay or performing other social duties. Engagement in economic and social activities is vital for contemporary Indian elders, since no universal social support schemes are available for the aged. Furthermore, more men than women participate as the main worker in the manual-labor economy of India (Biswas, 1994). The low participation rate of elderly women in the labor market leaves many economically dependent on their husbands and children (Nayar, 1994; Bannerji, 2002).

The majority of Indian women are at a severe disadvantage in both the marriage and labor markets (Bannerji, 2002). Most seem to rationalize their social position by idealizing the Indian cultural tradition that a man, whether husband, son or even uncle, is the caretaker of women in the family, regardless of their geographical location (Dandekar, 1996; Shirali, 1998).

The low education level among elderly Indian women is another reason why traditional patriarchal ideology is a resource in contemporary India. In India the illiteracy level among elderly women is very high, compared with elderly men and the total population (Mahadevan et al., 1992). With increased life expectancy, low levels of education, lower rates of economic participation among elderly women, and a lack of organized social welfare, the concept of the joint family household has remained extremely popular (Guha, 1992; Gurumurty, 1998). Willigen et al. (1996), in their New Delhi survey, illustrate the significance of the joint family household for upper middle class urban older adults: "Persons retire with very little financial security except for that provided by the family or their savings. Savings made during the lifetime of the

[27] The social aging boundary is arbitrary and is evidently associated with the 50th to 70th birth anniversary, or higher (Laslett, 1996). In the context of statutory retirement, the birth date varies among countries. In India it ranges between 58 and 62 years, versus 65 years in Canada.

individual are often used to get the children situated through education, dowry payments, and expenses involved in major life cycle rituals such as birth and death (p. 177).

Pensioners, largely males, have worked in the public and private sectors and live primarily in urban areas; they represent only 10% of the workforce (Bose, 1994). Most have no retirement benefits. Health, housing and other services that are available to many during their employment are discontinued at retirement (Srivastava, 1994). The loss of medical privilege in old age, when it is needed the most, brings great financial and psychological hardship for many pensioners (Reddy & Rani, 1994). Therefore, most people who work are not happy to retire and in many cases become socially dependent on their children (Mahajan, 1992), regardless of their geographical proximity.

Despite the development of many new social programmers and services, the majority of non-pensioners in India have no special health care services (Dandekar, 1996). In addition, very few voluntary organizations provide services to the aged (Srivastava, 1994; Gurumurty, 1998). Therefore, in old age most elders fall back on their life savings or children, particularly sons (Dandekar, 1996), "the Asian Indian model" (Pillai, 1985), and not on other agencies unless absolutely necessary. In a case study of living arrangements of the elderly in three communities in Uttar Pradesh, Srivastava (1994) found that a majority of elderly people enjoyed the company and support of their sons and other family members, and the frequency of isolation was insignificant.

Household-Oriented Practices: Son as Symbol of Indian Family Identity

In India, modernization, urbanization, technologization, and globalization have not disintegrated the family (Gurumurty, 1998). However, these social changes have contributed to the emergence of varied types of household[28] formations under the ideology of the traditional Indian family, the "bearer of virtues, values and of public reputation" (Devadoss, 1979, p. 43). Therefore, a strong household-oriented practice continues to place tremendous value on marriage and children (Gurumurty, 1998; Banerjee, 2002). To most Indians, the marriage ideal is the traditional Indian marriage:

[28] According to the 1991 Census of India, there are nine types of households: single member, nuclear pair, broken nuclear household, supplemented nuclear, broken extended nuclear, supplemented broken, lineally extended, collaterally extended, and other.

"Marriage is to every Hindu [Indian] not an act of mere pleasure, not primarily a source of gratification to his sentimental longings or romantic loves, but an act of duty, a matter of moral and religious obligation, absolutely incumbent on him to his ancestors" (Devadoss, 1979, p. 86).

Among children, sons are highly valued for the economic security of the aged (Devadoss, 1979), for the bliss and prosperity of the entire household (Gangrade, 1988), and for maintenance of lineage (Pillai, 1985). Economic security has had an important effect on fertility decisions in family planning in India. The poorer a family is, the more children they tend to have (Kanbargi, 1985). The pro-natalist attitude will prevail in India as long as sons are viewed as breadwinners for the family and caregivers for parents in their old age (Kanbargi, 1985; Desai, 1988; Dandekar, 1996). In the Indian patriarchal system, residing with sons is a tradition (Devadoss, 1979). After marriage a daughter becomes the property of her husband and in-laws, and the father loses all rights over his daughter (Dumont, 1980). Based on this traditional cultural ideology, sons are thought of as "old age insurance" and properties are usually transferred to the sons as a premium (Kanbargi, 1985). Biswas (1985) argues that this concept formed around non-pensioner and agrarian workers who had no alternative but to live either with their unmarried children, whom they still controlled, or with their married children, taking care of grandchildren.

Today, this patrimonial joint family household remains; its tenancy tends to be longer among affluent families (Devadoss, 1979; Yadava et al., 1997). Reddy and Rani (1994), in their study of Indian pensioners' living arrangements, note that pensioners' higher educational aspirations for their children motivate many of them to live with unmarried children. There is substantial reciprocity between married children and elderly parents for the prosperity of the family. Without complaining, elderly women help children with housekeeping, provide care when there is illness in the family, assist with childcare, and give advice about child rearing[29]. It seems Indians are used to psychologically linking "familism" with identity.

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[29] In Indian tradition, woman embodies sacrifice (Devadoss, 1979). Therefore, a mother who feels lonely, isolated and psychologically wasted is viewed as a curse to the family (Davar, 1999), since her behavior could negatively affect the family's growth.

The tenure of joint family households shows the cognitive connection between tradition and power (Davar, 1999). The content and nature of exchange shapes an individual's position in the social structure (Willigen et al., 1996, p. 425). In particular, the degree of involvement in decision-making in financial matters is the most important indicator of the elder's status in the Indian family. Pensioners have a higher status in the family than non-pensioners, because together with their adult sons they control the family's financial affairs (Reddy, 1994).

Daughters-in-Law: Sustainers of Indian Culture and Tradition

In contemporary India, family remains the main caregiving institution for the elderly (Guha, 1992). This traditional social arrangement may not always fulfill the hopes of elders (Willigen et al., 1995; Yadava et al., 1997), but it is the main resource available to all elders (Kanbargi, 1985). Elderly people of India and throughout the world suffer from many age-related illnesses and other diseases. However, unlike most industrialized countries, in India nearly 75% of the total population and almost 80% of the aged reside in rural areas with a minimal level of medical/health services (Roy, 1994) and other age-related organized programs (Dandekar, 1996). Lack of medical care and communication with doctors has forced many rural elders with health problems to continue to depend on family, ethnomedicine (Behera & Parida, 1991), ayurvedic medicine (Pillai, 1985), and magico-religious practices (Kakar, 1982). Most treatments are undertaken in communication with adult children and other kin (Behera &Parida, 1991). However, a large segment of the elderly in India still experience anxiety (Gurumurthy, 1998) about who will care for them when they are disabled (Guha, 1992).

Caregiving has a distinct meaning for Indian elders, particularly when they become frail or incapacitated by illness. Family sociologists in all societies have observed that women play the major role in caregiving (Walker, 1992). In an Indian household, the caregiving duty falls on the daughter-in-law (Guha, 1992). This discrimination based on the sex and marital status of women puts most Indian women in severe social constraints. While the man's family makes all decisions about care and other end of life events, Davar (1999) & Banerjee (2002) point out that an Indian daughter-in-law's role in the family includes not only procreation, but also taking care of the elders. Along with their other

household chores and employment (Banerjee, 2002), they act as primary caregivers for the ailing in-laws (Reddy & Rani, 1994), rather than sons or daughters, organized facilities or professionals. This traditional Indian household role, Banerjee (2002) argues, makes Indian wives provide unpaid family labor, performing women-specific tasks within the household economy. Most women undertake this traditional role, and it is an important factor contributing to the emotional problems of married women (Davar, 1999).

This role sometimes leads to conflict among siblings. Many Indian feminists argue that traditional Indian household practice is oppressively patriarchal. It is important to know how people use tradition to differentiate social values and behavior among different genders, family members, kin groups and classes (Davar, 1999). For example, in India, elders usually describe a married daughter as paryadhana (property of others) and argue that, according to tradition, their daughter must provide care to her elderly in-laws and not to her parents. However, in the last fifteen years, such traditional ways of thinking are gradually eroding among the urban, educated, older population. In a survey, Dandekar (1996) found that with the advance of old age, parents prefer daughters for caregiving. Their rationale is that daughters provide better care in times of crisis. A similar result was found among Singapore Indian families, even though living with a son is supposed to be the cultural norm (Mehta et al., 1995). So far, however, most studies show that the majority of Indian elders live with the son's family (Chakraborty, 1990; Mahadevan et al., 1992; Nayar, 1994; Reddy, 1994; Dandekar, 1996).

The last major social tradition and role of a daughter-in-law involves the social honoring of the dying elderly. This traditional Indian cultural practice is an important aspect of filial doctrine (Devadoss, 1979), that only the married son and daughter-in-law are allowed to offer ceremonies and prayers to release an elder's soul from the cycle of birth and death. Particularly significant for Hindus (Dumont, 1980), the practice is also common in other Indian communities. According to Hindu patrilineal ideology, it is the son who after death rescues his parent (particularly his father) from hell or *put* (Ibid). Many Hindus believe that by performing such ritual they will join the Godhead or ancestors (Pillai, 1985) and attain salvation (Devadoss, 1979). Belief in ancestor worship or achieving salvation endures in many contemporary Indian homes and is a major

component of an elder's decision-making process regarding where to spend the last stages of the life cycle in the world (Pillai, 1985).

In summary, cultural traditions related to duty and marriage are central to most Indian households and communities. In India, the lack of social provisions for the elderly forces many to depend on their sons and their sons' wives. The comparative demographic data on elderly women discussed earlier suggest that women in this cultural group will soon begin to outlive men in large numbers. Many elderly women experience social, housing, work and economic changes with aging and increased life expectancy. To safeguard and maintain the quality of life of elderly immigrants, particularly in the area of mental health, we need to understand the cultural history of the immigrant group. Chapter 3 provides an overview of cross-cultural studies on South Asian immigrant elders and their mental health, particularly on elderly EIIW.

CHAPTER THREE

AGING ELDERLY VISIBLE MINORITIES, WOMEN AND MENTAL HEALTH: A REVIEW OF LITERATURE

> The first thing to do after you get an idea for a piece of research is to find out what has been done. It is impossible to overemphasize the importance of a thorough literature search. Without a truly heroic effort to uncover sources, you risk two things: wasting a lot of time going over already covered grounds, and having your colleagues ignore your work because didn't do your homework (Bernard, 1994, p. 118).

A growing health-related literature addresses mental distress and other mental health concepts (Dressler, 1990; Estroff et al., 1991; Pang, 1994; Mirowsky & Ross, 1995; Fenton & Sadiq-Sangster, 1996; Shelly et al., 2000; Mirowsky & Reynolds, 2000). This literature examines both folk and scientific perspectives regarding mental health conceptions and behaviors (Foucault, 1965; Kleinman, 1980, 1988; Kakar, 1982; Kleinman & Good, 1985; Blazer, 1990; Pang, 1994; Gutmann, 1997).

In addition to the variable meanings of mental distress across societies, the health literature illustrates the differences in experiences of mental distress among people. For example, psychological distress is a major health problem among immigrant populations, particularly visible minorities living in western societies (Vega & Rumbaut, 1991; Simic, 1993; Saldov & Chow, 1994; Thomas, 1995; Silveira & Ebrahim, 1995; Rumbaut, 1995; Noh & Avison, 1996). In addition, elderly women are twice as likely as elderly men to experience mental health problems, particularly depression (Richardson, 2001, p. 86). Depression, anxiety, grief and loneliness are common among older women because of personal and sociocultural changes that take place in their later years (Heidrich & Ryff, 1996; Lee et al., 1996; Stenchever, 1996; Shephard, 1997; Falsetti & Ballenger, 1998). Several ethnogerontological studies have examined the mental health issues of elderly visible minority women (VMW), focusing on depression (Kuo, 1984; Mui, 1996; Yee, 1997; Davis, 2000), anxiety disorder (Adams & Williams, 1995; Tran & Dhooper, 1997), post-traumatic stress disorder (Kinzie et al., 1990; Ebrahim et al., 1991), and more recently suicide (Diego et al., 1994; Hu, 1995).

This chapter reviews much of the literature on elderly VMW[30] and mental health in western societies. Its purposes are to discuss what is known about aging VMW's mental health status, and equally important, to explore variations within this ethnic population. VMW are not a homogeneous ethnic subgroup (Mohanty, 1991; Agnew, 1996; Yee, 1997); they comprise people from diverse cultural, historical and geopolitical backgrounds (Badet & Howatson-Leo, 1999; Lindsey, 2000; Chard, 2000). Mental health data available on elderly VMW do not typically address place of birth but instead focus on the broad categorization of visible minority descent (Bhattacharjee, 1997).

This chapter is organized into two main sections. First, I assess the contribution of some of the key literature about elderly VMW and mental distress. Second, I present the symbolic interactionist perspective and outline my analytical framework, with particular attention to discussion of how both existing theories and elderly visible minority women's voices are productive of a new understanding about mental distress among elderly EIIW in Canada.

I. Explanations about Mental Distress and Healing among Elderly Visible Minorities and Women

The available literature on mental health issues of elderly VMW, including EIIW, is examined within three broad frameworks: (a) environmental explanations of mental distress, (b) racial/ethnic explanations of mental distress, and (c) cultural explanations of mental distress[31].

A. Environmental Explanation of Mental Distress

Since the 1970s, environmental arguments have been widely used to explain the prevalence of psychological distress in VM populations. The environmental arguments,

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[30] Many of the elderly VMW are refugees who were displaced because of civil war, political turmoil or famine in their homelands (McKelvey et al., 1993; True, 1995; Fernandez, 1999; Davis, 2000). Others migrated in search of economic advancement for themselves and their children (Rait & Burns, 1997; Thobani, 1999). Most migrated to join other family members in chain migration (Jayakar, 1994; Meleis & Hattar-Pollara, 1995; Basavarajappa, 1998). A few, who had immigrated in the early part of the 20th century to rejoin their husbands, were later perceived as potential threats to the socioeconomic security of white societies such as Canada and the United States (True, 1995).

[31] Gaylord's (2001) psychological analysis provides four determinants of aging experience of elderly women: biological, social, cultural and environmental. For other examples see Gallagher's (1987) *The Sociology of Mental Illness*; Alarcon, Foulks, & Vakkur's (1998) *Personality Disorder and Culture*.

which stemmed mainly from a structural-functional paradigm[32], are considered under four common themes: immigration strain, violence, economic factors, and acculturation.

Immigration Strain

Many immigration and settlement specialists contend that immigration strain is an inevitable part of immigrants' adjustment and settlement process (Chan & Indra, 1987; Berry, 1990; Wray, 1991; Gupta, 1991; Falk, 1993; Meleis & Hattar-Pollara, 1995; Ying et al., 1997). Some, sociopsychological theorists, such as Beiser (1984), deCosta (1993), Leung, (1996) and Mehta (1998), describe immigration strain as a passing social stressor that is healed with time and accommodation in the new country. Postcolonial ethnogerontological feminists, however, argue that regardless of length of stay, immigration threatens many elderly VMW's psychological comfort. For instance, Darlene Yee (1997), a demographer and feminist, observes that among Asian[33] Americans living in the United States, elderly Chinese women tend to show the highest risk of psychological distress and/or depression. The question is why?

Loss Theory: In the context of immigration stress, this theory has repeatedly shown the correlation between immigrants' various losses and their mental health (Atkin et al., 1989; Boneham, 1989; Beiser, 1988; Baker, 1993; Furham & Shiekh, 1993; True, 1995; Williams et al., 1997). The type of losses observed, however, varies with ethnic groups, immigration history, gender and age. For instance, Rait and Burns (1997), in a review of South Asian elderly immigration and health literature in the UK, reveal that loss of homeland, culture, family and language are associated with elders' psychological problems. Furham and Shiekh (1993) provide another example: results of 100 interviews from the UK indicated that South Asian female immigrants from the Indian subcontinent have a harder time adjusting; however, second generation immigrants experience more

[32] The classical structural-functional framework is normally described as normative/positivist sociology, where the priority is to the social system over the individual. In particular, this framework studies the structure of the society, where people reside, and how these people function. It also helps explain the consequences of human behavior on society. As a result, Marshall (1996) states, "The analyses typically examine patterns and relationships among structural variables, such as rates of behavior" (p. 15).

[33] Asians are people who originate from Far Eastern countries such as Japan, China, Korea, Cambodia, Vietnam, Laos and others.

mental distress than first generation immigrants[34].

Place of Origin Effects: Silveira and Ebrahim (1995) and Acharya (1998) discuss the influence of place of origin on the levels of mental health problems. For example, Kim's (1987) Canadian study of elderly Korean and Chinese women identifies depression and anxiety as main measures of immigration stress. Cochrane and Stopes-Roe (1977), Diago and associates (1994), and Ananthanarayan (1996) have extended the debate by including feelings of worthlessness and behavioral dimensions such as social isolation and suicide among the diverse elderly VM population. Adelstein and Morden (1975), in their British study of South Asian immigrant women, observed that the highest number of suicide victims were older women who were new immigrants. One possible explanation for this trend follows. In the 1960s and 1970s, immigrant women from the Indian subcontinent[35] had lower levels of education compared to their men. Many lacked English language proficiency, experienced social isolation, and lacked confidants[36]. Other observers echo these conclusions (Norman, 1985; Boneham, 1989). In addition, since most of these women came from countries where females generally receive less medical care than men (Cattell, 1996; Bonita, 1998; Davar, 1999; Collumbien et al., 2001), many were unaware of the availability of community social and health services (Atkin et al., 1989). Gupta (1991) in a British longitudinal psychiatric study (1969-1983) observed that many South Asians were diagnosed with functional psychosis, yet they made less use of inpatient psychiatric services at the hospitals during follow-up. Gupta speculated that a large proportion of the immigrant group did not use medical and psychiatric services because of geographical mobility and the use of traditional healing practices.

More recently, British mental health studies of South Asians and the aging immigrant population revealed in a comparative study of South Asians from the Indian subcontinent and Caribbean that women aged 55+ have a lower suicide rate (Raleigh 1996). Raleigh attributes the cause for the lower level of suicide rate among elderly South

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[34] First generation immigrants are people who were born outside the present country of residence. In this study, the South Asian first generation immigrants were born in India, Pakistan and Bangladesh.

[35] The Indian subcontinent includes countries such as India, Pakistan, Bangladesh, Sri Lanka and Nepal.

[36] The correlation between language barriers, social support and suicide rates has been observed in other ethnogerontological studies (Hall, 1993; Fernando, 1995; Chen, 1997).

Asian immigrant women partly to their longer residency in England and Wales. The effect of the length of stay and low suicide rate is partly supported by Ananthanarayan and Cochrane's (1999) analysis of mental health of elderly Asian Indians in the UK. In this study, length of stay was negatively related to mental distress symptoms levels of elderly Indian men (p. 407).

Although immigration is associated with mental health conditions of elderly VMIs and women, it is hard to determine the extent of the distress symptoms because of the process of data collection (Ironstone-Catterall, 1998) and methods of assessment (Silveira & Ebrahim, 1998). So far, most of the mental health status information of elderly VMIs has been primarily produced from hospitals, community psychiatry services, community surveys and clinical samples (Downs, 1996; Rait & Burns, 1997; Padgett et al., 1998; Bhui et al., 1998; Ananthanarayan & Cochrane, 1999; Livingston & Sembhi, 2001; Livingston et al., 2003). The emphasis on clinical analyses makes it difficult to determine with accuracy the prevalence of mental health problems among this diverse population. Bhui (1997) argues that in ethnocultural psychiatry research many distressed non-western individuals, such as the elderly EIIW, may not meet the criteria for a formal diagnosis and are likely to be missed from treatment. Similarly, as Hooyman and Kiyak (2002) suggest, since cultural factors influence the diagnosis of mental health problems, the data available may not reflect the true mental health status of this highly diverse ethnic population (p. 475).

The Cultural Component of Immigration Strain Experience: While Rait and Burns (1997) observe the influence that place of origin has on individuals' thinking about and expression of mental distress, cross-cultural specialists within the structuralist tradition conceptualize place of origin, or "ancestral origin," as a key cultural determinant of the distress experience. In a comprehensive comparative study of inner-city areas of the UK, Rait and Burns observed that the elderly population from South Asia had a low rate of mental distress compared with the elderly white population. The respondents were able to articulate distress in psychological language using terms such as low mood, heartache, anxiety and depression. Finally, the aged South Asian immigrants linked their distress experience to social issues such as housing, finances, unemployment, isolation, racism, and family problems and not to immigration.

Effect of Immigration Category on Mental Health Status: Some cross-cultural distress literature in Canada indicates that immigration category can make elderly immigrants and VMW vulnerable to mental distress[37] (Kim, 1987; Negi 1996; Majumdar et al., 1999; Auger & Tedford-Litle, 2002). Desai (1992), taking an activist approach, has linked immigration category to mental health condition, particularly women who have entered under family class as "householders" (Giles, 1999). South Asian elderly women who have immigrated to Canada as dependants are vulnerable to anxiety and depression, especially those with unrealistic expectations about the extended family's role in providing support to them in old age (Desai, 1992). To explore in greater detail the relationships of immigration category, gender, aging and culture with mental distress experience, Desai advocates for longitudinal mental health research involving immigrants such as EIIW in Canada, including the aging VMIs who arrived after the Second World War (Kanungo, 1992; Livingston & Sembhi, 2001; Chappell et al., 2003).

The literature suggests that most elderly VMW and men experience some level of mental distress related to immigration. However, a "monocausal" explanation (Ritzer, 2000) that migration per se causes clinical psychological disorders is incorrect. It is equally inaccurate to conclude that all Asians experience severe depression (Yee, 1997) or that South Asians do not experience severe psychological distress (Williams & Hunt, 1997; Bhui, 1997; Silveira & Ebrahim, 1998; Livingston et al., 2003). Many more factors than immigration contribute to the understanding and experience of mental distress. It is necessary to identify the risk factors for mental health problems of elderly VMIW before changes can be made.

Desjarlis et al. (1995) make this cogent argument:

> Migration alone does not necessarily lead to poor mental health. Rather, a number of forces, from unemployment status to housing conditions to traumatic events before, during, or after dislocation, can lead to psychological distress. The key factors that determine a migrant's well-

[37] Kim (1987) describes Korean immigrant elders as "captive immigrants" because of their sense of responsibility towards their family. Most have immigrated under the family class program, and the only role given to most of elders in Korean households is babysitting. It appears that such a limited role does not provide the elderly with the opportunity to become fully integrated into Canadian society and thus many experience psychological distress.

> being include: whether one adapts well to the changes brought on by migration, whether one is living in a safe and healthy environment, and whether one can live a productive, meaningful, and culturally integrated life. Two groups are therefore at great risk for distress: those who travel to, live and work in another location only to end up living in isolated, exploitative conditions; and those who seek refuge from starvation, violence, and political turmoil. (p. 137)

Violence

Prevalence Data: Epidemiological data on violence and mental distress in the elderly EIIW population are rare. However, recent published cross-cultural research has identified war, forced migration and domestic violence as important external factors influencing VMW's emotional and physical wellbeing (True, 1995; Rumbaut, 1995; Isaac & Prothrow-Stith, 1997; Zaman, 1999; Indra, 1999; Abraham, 2000). Wartime trauma studies indicate that the extent of mental problems varies based on gender, age and country of origin (Beiser, 1988; Rumbaut, 1995; Antai-Ontong, 1997; Stetz, 2003). For instance, Mollica, Wyshak, and Lavelle (1987), in a study of refugees in a war camp on the Thai-Campuchean border, observed the highest level of psychological distress symptoms in women and children. Gong-Guy (1987), in a statewide needs assessment in California, observed that the incidence rate of recurring symptoms of posttraumatic stress disorder (PTSD) is higher in women than men from Laos, Vietnam and Cambodia. Chung (1991), further analyzing Gong-Guy's data, noted that among the three Southeast Asian refugee groups, older Cambodian women experienced clinical psychiatric syndromes the most.

Male Violence against Females: Studies on wartime sexual violence experienced by refugee women have convinced Elmadmad (1999) that women are more likely to face gendered violence before, during and after fleeing their country of origin. The gendered violence argument, based on the patriarchal societies model, maintains that "Societies are structured as such where males have higher status and power than women" (Burn, 2000, p. 33), and that "Governments argue that men 'need' sex with women, and that if women are not provided, rape is the unavoidable result" (Stetz, 2003, p. 140). Therefore gendered violence remains a significant health risk factor for women throughout the lifespan (Chen, 1997).

In addition to the gendered stratification argument, Chung (1993) proposes that the length of time women spend in refugee camps is associated with psychological distress. The argument is that women's repeated exposure to sexual violence, crime and death of family members increases their chances of experiencing depression, bipolar disorder and anxiety (Chen, 1997). The resulting loss of control and social stigma has led many women to perform mutilation of their body parts, or suicide (Mollica & Jalberta, 1989).

Feminists, gender theorists and clinicians such as Bernardez (1984), Bhattacharjee (1997) and Giles (1999) are concerned about domestic violence and mental distress in the diverse VMW population. They argue that women's traditional patriarchal role of subservience to authority not only makes them vulnerable to violence and severe depression, but also affects statistics on domestic violence and violence against elderly women. As Crawley (1999) explains, "Women who have been raped or sexually abused are often unwilling to report the abuse because they feel degraded or ashamed, or fear that they would suffer social stigma should they disclose what has been done to them" (p. 314). Such behavior also hinders information disclosure and compilation of accurate statistics on violence against women (Gilad, 1999; Abraham, 2000) and elderly people in our society (Tindale et al., 1994). For example, Tustian (1999), the manager of the Community Services Department for Edmonton, Alberta, Canada, cautioned that in cities spousal violence can be *very* hidden, especially among immigrant populations who are reluctant to seek outside help. In 1998 Tustian's department was aware that 57% of women who were injured in a spousal violence incidence did not report the violence to the police, and 51% of women who were assaulted more than ten times did not report the violence to the police (Tustian, 1999, p. 11). Such under-reported abuse statistics, Pierce & Trotta (1986) suggest, also reflect the secrecy of the behavior.

These works have not only provided a synthesis of available studies on violence against elderly VMW, but they have also highlighted the paucity of studies of other high risk subgroups, such as the elderly EIIW, and the various types of violence. One important weakness is that "The patriarchal explanation remains ethnocentric" (Burn, 2000, p. 38). Feminists from a global perspective argue that this model explains a

particular form of gender violence that is common in Western cultures. Davar (1999), inspired by critical feminist thinking, argues that in the West violence against women is usually perpetrated by men, especially in domestic contexts where violence is high. In Indian communities, however, domestic violence often also involves in-laws, children and other extended family members, and cuts across class and educational barriers. Moreover, the causes of physical and psychological abuse include money problems, dowry, marriage, son preference, and jealousy, suspicion of women's character, housework and alcohol-related abuse. Davar (1999) emphasizes that violence in India is "patriarchal" (referring to household power relations), rather than male against female (p. 106). Therefore, elderly women in India are a high-risk group for psychological abuse (Behera & Parida, 1991) as well as physical abuse. Although Davar and other Indian social scientists have provided some clues about psychological abuse of elderly EIW, the degree to which any results from India or other VM groups can be applied to the elderly EIIW in Canadian situation is unclear.

Economic Factors

Research indicates that social class, finances, and labor force performance are decisive in terms of reproduction of mental distress with increased aging (Bernard et al., 1995; Heidrich & Ryff, 1996; Butler et al., 1998; Gee & Gutman, 2000; Cockerham, 2000; Chappell et al., 2003). These studies show the commonalities between mid-life and older women and men (Yee, 1997; Ceria & Shimamoto, 1998; Quadagno, 1999; Hooyman & Kiyak, 2002). They also reveal some of the economic variations and diversity relating to ethnicity and race, class, disability and sexual orientation (Bernard et al., 2000).

Social Class: The social class explanations (Markides et al., 1980; Tausig et al., 1999; Dixon-Mueller, 2001) focus primarily on socioeconomic position in societies. In Western cultures, a person's social class is largely defined based on indicators such as income, education and employment resources which vary by age, gender, marital status and ethnicity. Giachello (1997), reviewing empirical studies on the mental health problems of elderly Americans living in the United States, found that Latino women are

at a higher risk of developing serious mental illnesses[38]. The major determinant is their lower socioeconomic position in American society[39]. Similarly, Blakemore (1985), Rubin (1997), and Ceria and Shimamto (1998) report that elderly VMW belonging to the lower class experience more mental distress than non-whites, native-born and other white populations as a whole in the United States, UK and Canada.

The class inequality explanation is very insightful because it provides us with the basic objective assessment of individuals' socioeconomic status in societies (Bernardez, 1984; Muszynski, 1994; Dixon-Mueller, 2001). But problems arise when the evaluation is undertaken using the standardized Western definition of the term *social class*, explaining class inequalities with indicators that are common to European American and European cultures. Many of the world's societies are agrarian; in India, for example, people still live in an agrarian existence where social stratification continues to be influenced by caste[40] and ascribed employment (Dumont, 1980; Macionis & Gerber, 2001). Therefore, it is unclear how social class affects the lives of elderly EIIW from India, now living in Canada.

Financial Stress: While class analysis paid more attention to socioeconomic status, financial stress theories focus on poverty and public policy (George, 1992; Hardy & Hazelrigg, 1993; Sperry, 1996; Moen, 1996; Bolton, 1997; Quilodran, 2001). In two cross-cultural comparative mental health surveys of ethnic minority elders in the UK (Silveira & Ebrahim, 1995; Ebrahim et al., 1991), researchers observed low correlation between financial stress and symptoms of anxiety and depression among elderly Gujuratis, and high correlation among Bengalis[41]. In addition, Silveira and Ebrahim's most recent (1998) analysis showed differences between groups living in North and East London.

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[38] Mental illness refers to all clinical psychological problems, such as depression, psychoses and anxiety disorder.

[39] In an American study, Giachello observed that demographically a large number of Latino women are single parents. They are less educated, with a high incidence of poverty. Most American Latino women experience language barrier and acculturation problems and have the least access to community health care services.

[40] For further description of India's caste, class and jati system, see A. Beals, *Gopalpur: A South Indian Village*. Toronto: Holt, Rinehart & Winston, 1979.

[41] People who immigrated from Bangladesh.

Survey specialists Rait and Burns (1997) describe British South Asian immigrant elders as relatively affluent and having high socioeconomic status. Ananthanarayan (1996) adds that these immigrants from the Indian subcontinent have adjusted on most indices, such as family and employment. These findings led Silveira and Ebrahim (1998) to recommend a move beyond biomedical standardized assessment of psychological distress among ethnic elders. They concluded that existing methods for measuring mental health problems are not straightforward for the cross-cultural population and that further work is needed. Similar comments have been made by academic feminist gerontologists such as Williams and associates (1997), Yee (1997) and Auger and Tedford-Litle (2002) in the UK, United States and Canada. They suggest that different methods for cross-cultural research and public policy[42] studies would expand knowledge in this field.

Labour Force Performance: Another focus of the psychoeconomic perspective is on labour force performance. Most cross-cultural research on labour force performance and psychological distress has focused on unemployed young and middle-age immigrants (Johnson, 1989; Vega & Rumbaut, 1991; Baer, 1996). A computer search of Psychlit, Sociofile, AgeLine, Medline, CINAHL, and Statistics Canada revealed no studies on the connection between salaried employment, underemployment and unequal employment opportunities, and mental satisfaction among older EIIW in Canada. However various quantitative indicators have been provided to illustrate that elderly EIIW, like many other VMW, are less likely to be employed (Statistics Canada, 1996b), and those who are employed work primarily to subsidize their family income (Quilodran, 2001). Therefore, many resort to lower paying jobs than do other women and East Indian immigrant men[43] (Coyle, 1997; Lindsey, 2000; Chard, 2000).

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[42] In the 1990s Canada's public policy on health care and pensions underwent a major change to fight against reduction in public debt. Consequently, as McDonald (1995) suggests, Canada's model of later-life income as social insurance is being replaced with a social welfare model. This change will have a significant impact on tomorrow's elderly, especially the VMI group members who tend to retire later and have less chance of getting OAS, GIS, or CPP benefits (Novak, 1997, p. 181). Moreover, many VMW have less chance of receiving an occupational pension because they are located in the "invisible economy" (Boyd, 1995), for example, as seamstresses or domestic workers.

[43] Badets and Howatson-Leo (1999) note, that despite the language abilities and high educational qualifications of recent immigrants in Canada, they are less likely to be employed than people born in Canada. Immigrant women were in an even more disadvantaged position in the 1990s. Their employment rate fell from 58% in 1986 to 51% in 1996, compared with Canadian-born women whose employment rate rose from 65% in 1986 to 73% in 1996.

Noh and Avison (1996) suggest that work-related stressors have both acute and chronic aspects. For example, older women who are unemployed for an extended period (chronic strain) experience affective disorders such as depression and anxiety (Rife, 1997). It is, therefore, important to consider both acute stressors and chronic strains relating to work in elderly EIIW. As Phillips (2000) states, "A woman's identity too is increasingly shaped by work" (p. 43).

Retirement: Research continues to show a significant link between types of retirement and the mental health of retired people (Arber & Ginn, 1995; Hayslip et al., 1997; Ross & Drentea, 1998; Skucha & Bernard, 2000; Chappell et al., 2003). The attitude of retirees toward retirement is also important. For example, when retirement is viewed as "deserved leisure," there is no association with retirement distress (Skucha & Bernard, 2000). Similarly, Ananthanarayan and Cochrane (1999) observed that "place of retirement" is one measure of retirement stress among immigrants. They note in their British cross-cultural study that the decision to remain in Britain after retirement by many elderly Asian immigrants has contributed to increased stability in their mental health.

In spite of positive retirement experiences among Asian immigrant elders in the UK, Rife (1997) points out that it is essential to be sensitive to clues about the retirement activities of older VMW. These individuals are said to bear more financial problems than others in old age (Hooyman & Kiyak, 2002), because many have not worked outside the home. Those who have are over-represented in sales and service-sector jobs with no pension benefits or low rates of pension coverage in these areas (Rubin, 1997; Rife, 1997; Chard, 2000). Moreover, older women are much less likely than older men to receive private pension benefits (Arber & Ginn, 1995; Rubin, 1997). Therefore, they are a high risk group for financial strain and psychological distress.

Wanner and McDonald's (1986) Canadian study reaffirms and expands the retirement inequality hypothesis by stating two key contributing factors in the elderly VM Canadian population. First, most VMIs, particularly women, are employed in the labour-intensive low-wage sectors (Bolaria, 1994; Das Gupta, 1994; Kelly, 1995), or have part-time, seasonal and non-unionized work (Das Gupta, 1996) where they are often denied occupational pension plans (Novak, 1997). Second, many VMIs have less chance of

receiving government sponsored social security benefits (Lindsay, 2000) because they may not have lived in Canada the required number of years[44] or may not have contributed to the Canada Pension Plan/Quebec Pension Plan (CPP/QPP) (Street, 1996; Basavarajappa, 1998). Among the eligible VMs, women tend to depend more on government transfer payments than do men (Chard, 2000, p. 232), as do elderly EIIW from India (Statistics Canada, 1996b).

Widowhood and Divorce: Financial strain is also caused by non-normative events such as widowhood and divorce (Butler et al., 1998). Women who are economically dependent upon their husbands often find their incomes drastically reduced with widowhood (Burkhauser et al., 1991), especially if they do not yet qualify for Social Security or if their husbands have not chosen survivors' pension benefits (Hooyman & Kiyak, 2002). In addition, Boyd (1995) points out that, foreign-born women in Canada are a higher-risk group for receiving prorated survivor benefits than Canadian-born women. Most immigrants enter Canada as adults and have not accumulated the years of lifetime earnings necessary for full benefits. Therefore, with increased longevity many VMW, such as EIIW, are likely to outlive their husbands and to receive survivor benefits based on the decreased spouse's C/QPP contributions (Boyd, 1995, p. 218).

Divorce increases financial strain for most elderly women (Rubin, 1997; Rife, 1997; Butler et al., 1998). Today, despite improvements in women's economic condition (George, 1992; Rubin, 1997; Phillips, 2000; Lindsey, 2000), divorce continues to be a key determinant of mental distress symptoms of older women (Hooyman & Kiyak, 2002). However, research in this area pertaining to elderly Canadian EIIW is almost non-existent. We need to explore and understand elderly EIIW's attitude to divorce and financial strain.

Acculturation

The acculturation perspective defines acculturation as an adaptation or assimilation process[45] in which an individual or cultural group undergoes change as a

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[44] In Canada, persons can qualify for Old Age benefits or other social programs funded by both levels of government only if they have lived in Canada for 10 years and are at least 65 years of age.

[45] E. V. Stonequist's (1937) book entitled, *Marginal man: A study in personality and culture conflict* is one

result of contact with other cultures. This analysis supports the hypothesis that level of acculturation is significantly associated with psychological phenomena. Acculturation stress can be of several types. The most common types of acculturation stress are psychological (Berry & Kim, 1988; McCabe et al., 1990); sociocultural (Ujimoto, 1994; Bolaria, 1994; Driedger, 1996), which includes language and clothing; and lifestyle acculturation (Giachello, 1997; Berry, 1997).

Psychological Acculturation: The focus of this explanatory model is psychological assessment of dislocated and relocated individuals and groups (Krishnan & Berry, 1992; Noh & Avison, 1996; Lopez, 1996; Lee et al., 1996). It has been well documented that perception of acceptance by the dominant culture, cultural orientation, and fluency of English language usage are central factors in the psychological acculturation process, reducing acculturation stress and emotional problems of immigrants (Berry, 1980; Vega & Rumbaut, 1991; Lopez, 1996; Yee, 1997; Livingston et al., 2003).

Social and Cultural Acculturation: Social acculturation may reduce acculturation stress and ultimately psychological distress. Mehta (1998) investigated the relationship between sociocultural acculturation and mental health among adult Asian Indian immigrants[46] living in the United States. Mehta used three psychological elements of Berry's stress and coping model (1980) and three aspects of mental health: psychological distress, acculturative stress, and satisfaction. The results of the regression model showed that acceptance and cultural orientation played crucial roles in mental health, independent of various social and demographic variables. In particular, respondents' feelings of being accepted by the host society and having positive attitudes toward Americans were related to better mental health. The correlation between mental health and sex disappeared when age was taken into account. Finally, the use of Indian language at home had no ill effect on Asian Indians' mental health in this study.

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of the earliest works on immigrants and acculturation in the United States.

[46] The 195 respondents were first generation immigrants born in South Asia, particularly India. They came from 15 of India's 25 states. They ranged in age from 24 to 66. Sixty percent were males and 40% females. Eighty-five percent were Hindus, and 94% had been in the US for over four years. Fifty-nine percent were naturalized US citizens. Of the men, 93% gave the reason for emigration as education and/or career opportunities; of the women, 32% emigrated for these reasons, and 56% to accompany a spouse.

Despite the contributions of social skill/cultural learning theorists[47], others working within the framework of cognitive paradigms argue that this model is too difficult to test in applied situations (Lopez, 1996), particularly when it combines group-level structural components and individual-level process components (Schonpflug, 1997). The second weakness is that the focus on social factors makes it difficult to explain the change in psychological outcome of immigrants in a new culture (Ward, 1997). Schonpflug (1997) suggests that the stress-coping framework is too narrow to explain the long-lasting changes in the individual following relocation to a new culture. Lazarus (1997) recommends that, for a detailed analysis of acculturation stress, emotion and coping processes of immigrants and displaced persons, attention must be given to the underlying cognitive and motivational dynamics on which they depend (Lazarus, 1997, p. 39). Many immigrants, particularly the elderly EIIW, are the product of accumulated life experiences and problems associated with settlement, ethnicity, culture, gender and old age, which in turn may yield diverse psychological outcomes (Thomae, 1981; George, 1993; Marshall, 1996; Ananthanaryan, 1996; Gutmann, 1997).

Lifestyle Acculturation: Lifestyle acculturation is one of the many behavioral consequences of immigration (Bolaria, 1994) and integration (Naidoo, 1985; Berry, 1994; Majumdar et al., 1999). Lifestyle acculturation includes change in behaviors related to diet (Krondl & Lau, 1993), leisure activities (Patterson, 1996), and sickness pattern (Yee, 1997). Most lifestyle acculturation studies are centered on the premise that a high level of lifestyle assimilation increases an individual's lifespan (Berry, 1990; Rait & Burns, 1997) but increases physical and psychological health problems (Kaplan & Marks, 1990; Zambrana & Britt, 1995; Giachello, 1997). According to this model, individual lifestyle choices are the immediate cause of illness and are primarily responsible for both prevention and treatment of disease and illness (Clarke, 2000).

Enas (1996) studied lifestyle acculturation and health of ethnic minority groups in the US, reporting that Asian Indians have the highest cardiovascular disease (CAD) of all ethnic groups studied. Similar result was observed by Silveira & Ebrahim (1998) among

[47] Berry (1997) has extended the model to include acculturation and mental distress issues relating to country of origin, country of settlement, type of group, language usage, group-level factors and individual psychological influences.

the Asian population in the UK. Teo (1997) ascribes the increased rate of CAD in Canada partly to high levels of cholesterol and fat in diet, and to physical inactivity. Abraham (1999) attributes CAD to ethnicity. Here the term ethnicity encompasses three characteristics: lifestyle, culture and genetics. This longitudinal study showed that Asian Indian men suffer more from CAD than do Asian Indian women. A number of studies illustrate the significance of recognizing the CAD risk level differences based on the level of acculturation in VM populations (Zambrana & Britt, 1995; Ralston, 1997), yet they fail to communicate the association between CAD and mental distress.

Moreover, some social psychiatry studies have found that, as with older people in all industrial societies, the older VMIs' incidence of emotional problems increases significantly when diseases or impairments become chronic (Henderson, 1994; Moneda & Gibson, 1998; Butler et al., 1998). Turner and Samuel's (1988) structured interviews clearly support this finding, concluding that disabled individuals are at an elevated risk for depressive symptoms and that this high level of depression characterizes both men and women of all ages[48].

Critical Evaluation of Environmental Explanations

Environmental arguments have been beneficial in identifying the social determinants of mental health problems of older ethnic minority immigrants (Patel, 1983; Gallagher, 1987; Rait & Burns, 1997; Livingston et al., 2003). Environmental explanations have also shown the correlation between social designation and biological attributes (Blakemore & Boneham, 1994; Blazer et al., 1996; Ananthanarayan, 1999; Ganguli et al., 2000; Davis, 2000; Cattell, 2000), such as symptoms of depression and anxiety (Livingston et al., 2003); development of acculturative stress scales (Krishnan & Berry, 1992; Ball, 1998); mental distress evaluation scales (Lopez, 1996; Mehta, 1998; Dana, 1998); enhanced counseling services (Fernando, 1995; Atkinson et al., 1998); expansion of several multicultural mental health training programs (Auger, 1993; Lo & Lee, 1993; Sair et al., 1998; Rhodes & Goering, 1998); and services in western countries (Dickinson, 1994; Weisman, 1998; Blanch & Levin, 1998; Ball, 1998; Aléman, 2000).

[48] In this study the investigators interviewed men and women aged between 19 and 91.

Nonetheless, a common criticism is that environmental theorists fail to incorporate rich contextual reasons to explain why mental health differences and inequities still persist among elderly VMs (Bhatnagar & Frank, 1997; Zhan, 1998; Hutchinson & Gilvarry, 1998; Guo, 1998). For example, Williams, Eley, Hunt and Bhatt (1997) contend that the UK ethnic minorities' psychological distress studies have fallen short in describing the overall experience of psychological distress among UK South Asians.

B. Racial/Ethnic Explanations of Mental Distress

Race Ideology, Politics and Discrimination Practices: The "Hidden" Politics of Health Inequality

There are many social and political debates surrounding race, health care and health inequality. A complete review of this complex situation will not be attempted here. Instead, the objective of this section is to examine how race ideology and market system (economics) serve both as a general indicator of the differential health pattern of a given society and a distinct set of issues on their own. The term 'race,' which Bourdieu (1984) describes as "social capital," has been utilized in a variety of ways by "rational agents"[49] (Ritzer, 2000) to produce hierarchies and inequities in health. This situation has been called the "racial politics of difference"[50] of the postmodern world (Ng, 1988; Bannerji, 1991; Omi & Winant, 1993; Blackburn, 2000; Kallen, 2003; Driedger, 2003). This argument, which stemmed primarily from a social-conflict paradigm[51], is discussed under three common conditions: cultural imperialism, politicism and discrimination. Any one of these conditions can be sufficient evidence of differences and inequities, although it is common to find them in combination. Health feminists and gerontologists such as

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[49] The term refers to people. This viewpoint rejects the Marxist proposition that development results from unintended consequences of human action, suggesting that human beings are active agents of development and social change. This perspective encourages researchers to synthesize Marxian and neoclassical economic views of *action* and *reward* for a better understanding of social phenomena. For Ritzer (2000), social phenomena – their structure and their change – are in principle explicable in ways that only involve individuals – their properties, their goals, their beliefs, intentions, and their rational choices (p. 171). It is important to examine empirically how concepts such as race and ethnicity have evolved over time and space. See Ritzer's *Modern Sociological Theory* for analysis of "Rational Choice Marxism". See Driedger (2003) and Kallen (2003) for further discussion of race and ethnicity in Canada.

[50] The focus of discussion throughout this thesis is *categorical* discrimination, prejudice, stereotyping and ethnocentrism, which provide the building blocks for the social construction and maintenance of majority and minority status.

[51] Social-conflict theorists believe that society is an arena of inequality generating conflict and change. See Ritzer (2000) and Wallace & Wolf (1999) for discussion of the social-conflict paradigm.

Sherwin (1996), Jocelyn Armstrong (2001), Bernard & Davies (2000), and Oudshoorn (2002) indicate that these criteria provide clear measures for understanding disparities in ethnic minority groups, particularly women's health outcomes.

Cultural Imperialism Produces Health Inequality: Giachello (1997) argues that people who are physically (that is, non-White) and culturally distinctive experience marginalization and unfavorable treatment. This is not to say, however, that all people of white color receive favorable treatment. Clearly they too have hierarchies and inequities, in which gender, age and class differences, among other characteristics, are quite apparent[52]. Nonetheless, stratification research has shown that VMs in general occupy lower status both objectively (social class category) and subjectively (attitude or bias) in our western society, depending on their skin color (Berry et al., 1976; Ng, 1993; Giachello, 1997; Thobani, 1999; Isajiw, 1999; Driedger, 2003). Categorizing all VMs, despite their diversities, under the single physical characteristic of skin color seems in many instances to translate into devaluation and provision of inadequate health care (Atkin et al., 1989; Disman & Disman, 1993; Bolaria, 1994; Meleis & Hattar-Pollara, 1995; Fernando, 1995; Dana, 1998; Atkinson et al., 1998).

Despite such unfavorable health results, why has this 'one-race model' (author's terminology) dominated western society's discourse[53]? Among many explanations, both positive and negative, the most important sociological argument is that this model dominates because of issues of control and power (Dickinson, 1994; Sherwin, 1996; Kandell, 1996). Henry and Tator (1994) argue that, in Canada, the 'race politics of difference' is inextricably intertwined with maintenance of majoritarian values and norms at a time when rapid sociodemographic and economic changes are occurring as a result of *new* immigration policy and economic globalization. They argue that the objective of most Canadian institutions, including the health care system and professionals, is to retain the status quo. Consequently, race ideology is being systematically exploited through the terminology (such as 'multiculturalism' or 'the pluralistic society') used by the state. In

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[52] See Laing (1992), Muszynski (1994), McPherson (1995), Rubin (1997), Gee, (2000) and McDaniel (2002).

[53] This concept draws on the work of Foucault that refers to a dominant or powerful way of thinking.

other words, this is a strategy of the powerful to maintain control and power:

> The conflict between the ideology of democratic liberalism and the racist ideology present in the collective belief system of the dominant culture of Canada creates fundamental dissonance. Although lip service is paid to the need to ensure equality in a pluralistic society, in reality individuals, organizations and institutions are far more committed to maintaining the status quo in order to stabilize or increase their power. (Henry & Tator, 1994, p. 1)

Although the notion of stratification by race is recent in Canada[54], Driedger (2003) outlines the traditional ideals of white Europeans that still influence the power relationship in the multicultural Canadian bureaucracy. For example, European dominance is linked with and influenced by views of colonialism, exploitation, white supremacy, and solidarity and cohesion (Driedger, 2003). Others argue that these ideals and views have led to the development and growth of 'ethnocentric' attitude (Schreiber et al., 1998), 'ethnic minority status' (Armstrong, 2001), and discriminatory services against people whose innate or historical origin is not associated with White European tradition (Markides, 1986; Ng, 1988; Bannerji, 1991; Ralston, 1992; Gelfand, 1995; Markides & Black, 1996; Thobani, 1998; Kallen, 2003).

Lipson et al. (1987) investigated the link between ethnocentric attitude and the delivery of health service in the United States. Although this study did not focus exclusively on older Arab American women, it found that several hospitals in New York inaccurately recorded information such as the national and cultural heritage of Arab American patients in general. Lipson et al. caution that basing assessment of a patient on practitioners' religious or cultural bias may result in misinformation, confusion and sometimes racist health care service.

Third World feminists such as Mohanty (1991) and Bhattacharjee (1997) were also concerned about the implications of cultural imperialism for VMIW. They situate their discussions in the context of the complex and contradictory history of Third World immigration to the United States. Their studies illustrate how, under the pretext of

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[54] Since pre-multicultural Canada was primarily made up of white immigrants from Europe and the US, traditional race and ethnic studies emphasized 'ethnicity' as oppose to 'race'. This changed after Canadian immigration policy was modified and the Human Rights policy developed. See Driedger (2003).

physiological differences and cultural diversity, all ethnic minority immigrants from Third World countries experience group-level social inequality and injustice in the host country. Against the backdrop of expansion and colonial history, Boneham (1989) argues that considering race, gender, age and class as relations reveals how racism, sexism, ageism and classism (popularly known as multiple jeopardy theory) have hindered immigrants from past British colonies such as the Indian subcontinent from receiving proper health and social services. Hutchinson and Gilvarry (1998) attempt to highlight the variable medical treatment experienced by ethnic patients. This empirical study examines medicine's differential decision-making power, evaluating British psychiatric services. For example, these researchers note that among all ethnic groups, Black patients are over-represented, particularly those born in the UK[55]. Blackbum (2000) suggests that this differential treatment pattern is not unique to the British psychiatric services but is also seen in heterogeneous countries such as the United States.

In the Canadian context, Auger and Tedford-Litle (2002) did not reject the minority and majority race hypothesis, but suggest that Canadian health care has not been in accord with Canada's multicultural charter. These feminist gerontologists explain how Canada's imperialistic ideology and the focus in reducing health care cost have politicized[56] the term 'race' through the use of quantitative method in analyzing, for example, Census data. Auger and Tedford-Litle believe, however, that this racial fabrication at least resulted in an exact count of Canadian VM population and also "assisted the decision-makers to construct us (the host society) versus them (the newcomer, immigrant, refugee population) categories for the provision of programs and services in ethnic elders' own language or based upon their cultural expectations, values, and understandings" (p. 128). Not surprisingly, existing research shows that colonialism,

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[55] For further examples of racial inequality in current capitalist multicultural psychiatry and psychotherapeutic programs and services, see Cochrane & Stopes-Roe (1981), Balrajan et al. (1989), Ahmed & Webb-Johnson (1995).

[56] Meleis & Hatter-Pollara (1995) explain that though racism and politicism have the same consequences, the origin of their inequality is different. Racism is fashioned by cultural bias (stereotypes), individual bias (prejudice) and institutional bias (discrimination). The term 'discrimination' is primarily rooted in physical characteristics and skin color (Isajiw, 1999). The term 'ethnocentrism' refers to viewing all the people and cultures of the world from one's own ethnic and cultural background (Atkin et al., 1989; Schreiber et al., 1998). 'Politicism' refers to bias based on political issues such as religion, culture, language (Meleis & Hatter-Pollara, 1995; Fernando, 1995), and economics (Ritzer, 2000).

exploitation and economic bias in the Canadian health care system have left many disempowered people out from research, intervention and service provision (Stevens, 1993; Bolaria, 1994; Clarke, 2000; Chappell et al., 2003). Aged EIIW living in Edmonton are a good example (Negi, 1996).

Politicism in Western Health Care Increases Health Inequality: In addition to cultural imperialism, the inequality theorists, who follow socialist feminist approaches[57], argue that western medical and health care also contributes to VMW's inequality in health care provision and different levels of health. This argument relates not so much to contextuality as to perception. For example, the present medical practice incorporating body, disease, the traditions of identifying[58], and strict registration requirements gives health service providers a strong sense of authority, prestige and status (Kendall, 1996; Shah, 1998; Oudshoorn, 2002; Freund et al., 2003). Medicine is known as a "patriarchal profession" (Dickinson, 1994).

Western medical knowledge and organizational values certainly have contributed to the eradication and control of certain types of disease and illness, and to the expansion of the health care field to better address today's changing society. However, there are many new health-care problems[59] (Bernardez, 1984; Maticka-Tyndale & Bicher, 1996; Clarke, 2000). Meleis and Hatter-Pollara (1995), for example, believe that despite many ideological and practical changes, the present health care facilities do not necessarily produce better health care. Instead, the health care system is an important structural stressor for VMIW clients, such as Arab immigrant women in the United States. Cross-cultural health specialists observe that some professionals' "geographical ignorance" and "cultural insensitivity" result in misinterpretation of non-White female clients' behavior.

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[57] Socialist/Marxist feminists believe that women are oppressed by society's structures based on the philosophy of capitalism and patriarchy. To understand women's experience and needs, they argue, it is important to combine the impact of patriarchy with some aspects of a more traditional Marxist approach (Zaman, 1998; Davar, 1999; Bernard et al., 2000).

[58] The five main assumptions of the biomedical model are mind-body dualism, physical reductionism, specific etiology, the machine metaphor, and the quest for mastery (Clarke, 2000; Freund et al., 2003).

[59] Dana (1998) reported evidence of conflict between western health care system values and health professionals' personal values in the delivery of multicultural psychological assessment. While the western health system dictates that psychologists use a multicultural assessment model for visible minority clients regardless of circumstances, in reality the cultural orientation scale does not do justice to the considerable heterogeneity of any one group (Lopéz, 1996, p. 456).

The consequence of this misinterpretation is differential and sometimes unequal health service provision. For example, Meleis and Hatter-Pollara (1995) found that health care service providers gave more attention to female clients who demonstrated outward symbols of assimilation or "Americanization" than to less assertive immigrant women.

Giordano (1994) reasserts this theory of differential treatment, suggesting that clinicians determine their assessment and treatment delivery systems not only by their professional knowledge and training, but also by their own cultural filters and presumptions, which may create distortions and inaccuracies in evaluating patients' behavior. Guo (1998) reports that elderly Chinese immigrant women's misinterpretation of western health care facilities, misinformation, high cost, and conflict with health professionals' expectations contribute to their underuse of western health care facilities. According to Guo, when new elderly Chinese immigrants come from a very rich culture of health beliefs and practices and move into an economic and cultural environment dominated by the technologically advanced health care system, they encounter hardship in dealing with service providers (p. 143). For Guo, the position of racial difference and subordination has discouraged many elderly Chinese women, even those who are seriously ill, from obtaining needed services from the western health care system.

In addition to the ethnogerontological health service utilization problem of elderly Chinese women[60], Gratton and Wilson (1988) argue that the use of the term *culture* in service facilities is not so much a reflection of the service providers' lack of cultural knowledge of clients as of a well-organized "hidden" political agenda. The term *culture* is often exaggerated and oversimplified by service providers for economic reasons rather than cultural ones. The current Canadian government's objective to reduce health care costs yet provide multicultural medical care to its population has prompted decision-makers to use terms such as *culturally sensitive health care* as a way to transfer the public institution's economic responsibility to private institutions such as the family[61].

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[60] Blanc & Levin (1998) describe another example of medical dominance and politics. The reluctance of elderly ethnic minority female patients to discuss health problems such as distress or stress with inpatient/outpatient mental health professionals came to be labeled as the "immigration syndrome". This medicalization of sociocultural behavior is another example of racism, sexism and ageism.

[61] Alternatively, many medical sociologists, anthropologists and gerontologists involved in analyzing cross-cultural health care provision have spent much of their time in generating literature about symbolic and

Several studies illustrate that, in the West, this institutional strategy began with the economic crisis in the 1980s (Atkin et al., 1989; Shenk, 1990; Giordano, 1992; Gee, 2000; Chappell et al., 2003), with no consideration of the negative social, economic, physical and psychological implications it might have on middle-aged and elderly VMIW (Hall, 1993; Negi, 1996; Bhattacharjee, 1997). Arguing from interventionist and multicultural viewpoints, Atkinson et al. (1998) attribute the lower use of outpatient mental health services by ethnic populations as structural unwillingness to change on the part of the modern social institutions.

Discrimination and Politicism Widens Health Inequality: The third major explanation of health inequality relates to discrimination. This widely used argument suggests that racial discrimination and politicism affect elderly VMW clients' health and wellness behavior, particularly in the context of utilization rates of western medical and health services and types of health care provider (Rhodes & Goering, 1998; Blakemore & Boneham, 1994). Using the 1983 Federal Employees Plan (FEP) database and weighted logistic regression models, Padgett, Harman, Burns and Schlesinger (1998) have shown that White women age 50 and over had the highest rate (3.22%) of outpatient mental health visits, versus 2.80% for Hispanics and 1.80% for Blacks. Although no other variables were significant for Black or Hispanic women, additional significant predictors for White women included educational level, geographic region, plan options, and inpatient mental health treatment of other family members. Other less significant variables identified that predict the number of mental health visits included ethnic congruence, provider type and setting for all three groups. For example, for Black women, ethnic congruence is positively associated with number of outpatient psychiatric visits, but it is negatively associated for Hispanic and White women (Padgett et al., 1998, p. 46). For all three groups, significantly higher levels of use were associated with visiting an office-based practitioner and with visiting a psychologist.

A few emerging studies of older Asian women's approaches to addressing racism, sexism and ageism in the western health delivery system (Yee, 1997; Chen, 1997; Louie,

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epistemological dimensions of depression or psychological distress and healing among various elderly cultural groups (Wong & Reker 1985; Johnson, 1989; Falk, 1993; Dossa, 1994; Ujimoto, 1995; Mui, 1996).

1998; Guo, 1998) have reported that the utilization of western heath services rate is *widening* rather than *narrowing* among this population. Zhan (1998), studying the health practice of elderly Chinese women in the United States, found that because of cultural conflicts concerning the power relationship between health provider and patient, language incompetence, and financial difficulty, a majority of elderly Chinese female clients hesitate to ask questions regarding prescribed medication or to verbalize their concerns for fear of public conflict. Zhan found that elderly Chinese women reduce their visits to western health professionals and combine the use of Chinese herbal medicine and western medicine, with a possible increase in risk to their health. Atkin et al. (1989), Naidoo (1992) and Meleis and Hattar-Pollara (1995) argue that cultural, gender and age stereotypes (for example, that older VMIW are subservient, powerless and abused, voiceless creatures) seem to minimize these women's willingness to seek help and discourage many from accessing health services, even when they need them (True, 1995; Yee, 1997; Bhattacharjee, 1997; Zhan, 1998).

Adopting pluralistic theories, Dunn (1990) and Biggs (1993) in their studies of midlife and older Black women in the United States argue convincingly that the strain of cultural bias has made Black women develop certain attitudes towards and perceptions about their own health. Dunn (1990), for instance, found that many midlife and older Black women perceive their health as good from their "local" perspective, even when it is not good from a "clinical" perspective. One explanation for this behavior is that older Black women play down their health problems as a coping mechanism against racism. This "psychological capital", a cognitive resource, to address perceived racial bias and institutional discrimination is further supported by Meleis, Dellafar and Lipson (1995). They propose that, fearing discrimination, denial of service and humiliation, many Arab immigrant women in the U.S. ignore the question of their country of origin in hospital records. However, it is unclear from these studies which age group of Arabic women engage in this hidden form of resistance. Arabic socialist feminist theorists have found that discrimination makes many Arab immigrants and women reluctant to keep appointments, to follow health regimens, to ask questions, or to comply with service provider's directives. Henley (1979) attributed a low rate of hospital admission cases of mental distress among South Asians in the United Kingdom partly to fear of being

admitted to a psychiatric hospital.

Hutchinson and Gilvarry (1998), in a study of British psychiatry services, report that second generation Black patients are more likely than any other group questioned to express preference for case managers of their own race. The researchers emphasize that "It is relevant to assess the demographics of the service providers, particularly with regard to age, cultural allegiance and ethnicity, as they may identify some of the problems that result in the dissatisfaction with services" (p. 96) among ethnic minority clients such as Blacks, Chinese or South Asians.

Critical Evaluation of Race and Ethnic Explanations

Clearly the racial and ethnic approach is an important resource for systematic study of cross-cultural mental health behavior. The categorization of people based on skin color arose out of biologically determined characteristics and still impacts immigrants and refugees in a new country (Bhattacharjee, 1997; Bhatnagar & Frank, 1997; Ngo & Tran, 2000; Grewal & Kaplan, 2002). Some attempt to retain or increase control, bring social change, or achieve their rights in a society by clinging to the historically constructed concept of race or place of origin (Isajiw, 1999; Driedger, 2003). It is important to consider the parameters of race, gender, age, culture, religion, and country of origin when studying aging immigrants and mental distress.

This study of mental distress among non-institutionalized aging EIIW in Edmonton focuses on country of origin as opposed to Indian ethnic heritage. Many EIIs who were born in and migrated from India believe that they are different from other EIs and South Asians (Rait & Burns, 1997; Bhattacharjee, 1997), because they have a unique sociopolitical history. A majority of Indians came to Canada from India as immigrants, not as refugees. From an immigration perspective, this criterion of immigration symbolically amounts to a higher social status than that of a refugee (Marfleet, 2002). Immigrants see themselves as a group who came predominantly for economic advancement, were not politically forced out of their country (like Tamils from Sri Lanka), were not asylum-seekers (like Asians from Uganda), and certainly have not come

to Canada to "live off the state,"[62] as western media often represent (Livingston & Sembi, 2001). Unlike Pakistan, which is an Islamic state, India is a secular country (Rait & Burns, 1997) where Indian culture and tradition originated (Dumont, 1980; Tilak, 1989) and are still maintained despite India's long history of colonization.

Today, India is often described as an imperial power by its neighboring countries in South Asia (Bhattacharjee, 1997; Abraham, 2000). Yet, like the First World imperial countries such as Britian and the U.S., India, a Third World imperial power (terminology mine), has no social security, national old age schemes for its elderly population, or health care programs (Dandekar, 1996). Nor are well-established community mental health services available for India's large population (Davar, 1999), except facilities available for clinical psychiatric problems (Nunley, 1996). In this sociopolitical environment, most elderly Indians believe that cooperation and togetherness are central for healthy aging (Yadava et al., 1997). Therefore, family and community have remained informally the most important structural pillars for old age in India. Despite such deep-rooted attitudes (Sharma, 1984; Mahajan, 1992), in the few available Indian aging studies, scientists have observed that many women in India are growing old in poverty with little or no support system (Behera & Parida, 1991; Guha, 1992; Reddy & Rani, 1994).

The Indian theory of duty, the social doctrine of classical Indian tradition (Chakravarti, 1995), has been found to play a crucial role in the psychology and everyday activities of Indians in India. The belief is that one's social, economic, health, or any other failure and success in life results from individual and group performance at every stage in life. In this cultural identity context, the concept of imperialism or nationhood may go beyond the notion of domination and exclusion. Many EIIs living in Canada may actually see their nationality as a positive means for distinction and identification (Bhattaacharjee, 1997, p. 310). Most important, this 'collective' way of thinking may provide individuals with strength and power to encounter the changes that may occur in their last stage of life in a foreign land. As Bhatnagar and Frank (1997) and Guglani et

[62] This term is used in to explain abuse allegedly carried out by migrants who come to Canada and depend mostly on Canadian social programs.

al., (2000) observed in their British mental health studies, some elderly EII men and women living in Britain consider culture and tradition the sole arbitrator of life and death, rather than any organized institutional treatment. It is, however, unknown how the past (in India) and present (in Canada) experiences of EIIW influence their construction of the meaning of mental distress once in Canada. The race and ethnic approach helps to show how a person's historic past influences his or her formation of preferences and ways to define everyday activities.

Like the environmental approach, race and ethnic explanations come with their share of criticisms, some of which are relevant here. First, this approach has been criticized for using EIIW as a "universal category" (Fenton & Sadiq-Sangster, 1996), in other words, a racial/ethnic group with the same sociopolitical history. Gender theorists, multicultural theorists, psychologists, anthropologists and gerontologists who support cultural pluralism, multivocality and fluidity assumptions have certainly criticized the use of universalizing theories on diverse populations (Blakemore & Boneham, 1994; Dossa, 1994; Agnew, 1996; Ralston, 1998; Thobani, 1999; Mehta, 1998; Davar, 1999).

Similarly, Basran (1999) argues that sweeping generalizations about all VMW, for example, have made the experiences of EIIW over sixty invisible in mental distress research (Negi, 1996). Using postmodern ideas and the feminist methodological approach of "talking through difference" (Ironston-Catterall et al., 1998), Mohanty (1991) warns against limiting the heterogeneity experience to such narrow universalizing theories: "Women cannot be assumed to be an already constituted, coherent group with identical interests and desires, regardless of class, ethnic or racial location" (p. 55).

The second major criticism of the race and ethnic approach is that it has never divorced itself entirely from studying "the effect of immigration which focuses on vulnerability of elderly VMIs rather than resilience and protection that may be afforded by, for example, close social groups" (Livingston et al., 2003, p. 31). Ethnogerontological mental distress research on elderly Asians has emphasized cultural competence, linguistic ability, housing and financial conditions (Patel, 1983; Weiland, 1991; Dossa, 1994; Bassi, 1995; Rait & Burns, 1997; Guglani et al., 2000).

The final criticism is that the race and ethnic approach uses broad western demographic categories (for example, race, income, gender and ethnicity) and rarely takes into consideration the major eastern demographic characteristics of elderly immigrants, which may influence their perception and management of mental distress. The main formal social systems that play central roles in the life of every Indian from India are *caste*, a special status ascribed by birth (Lamb, 2000; Maconis & Gerber, 2002), and the Indian government's old age schemes, which are available primarily to the destitute (Dandekar, 1996). These two social structures determine an Indian's life from birth to death (Lamb, 2000; Banerjee, 2002). For example, caste exposes many women to diverse experiences during their life-course ranging from marriage, widowhood, employment, household duties, and economic status, to abuse in interpersonal and social relationships. However, the caste category is not included in most research, possibly because it is viewed as the problem of Indian Hindus. In other words, caste was treated as a social stratification system limited to the Hindu community and not considered as a national characteristic. In fact it seems to be practiced informally by most Indians regardless of their religious backgrounds (Beals, 1979; Sharma, 1984; Willigen & Channa, 1991).

We cannot fully understand the attitude and behavior of elderly EIIW towards mental distress unless we look at the sociopolitical history of India. Researchers who use a race and ethnic approach to study the mental distress of elderly EIIs tend to remain too close to the issue of ethnicity. Thus, they leave out an important cross-cultural link, the Indian social stratification system. Yet this link is vital to a full understanding of the mental distress issues in elderly EIIW from India living in Canada.

C. Cultural Explanations of Mental Distress

Today, *cultural*[63] explanations are the preferred perspective in the medical/health

[63] According to McElroy & Townsend, "Culture means a way of life that a particular group of people follows. It also means unique characteristics of human beings in which the use and transmission of symbols, language, names and categories, rituals, rules, and other learned behaviors play an important role in the adaptation of our species" (1996, p.10). Similarly, according to McPherson, "The culture of a society or of a sub-group within a society develops when a group shares a way of life at the same time and place. The culture provides a symbolic order and a set of shared meanings to social life and is composed of nonmaterial and material elements" (1995, p. 31).

field in studies of illness, disease and mental health (Kleinman & Good, 1985; Kleinman, 1980, 1988; Dresseler, 1990; Estroff et al., 1991; Kaufert & Lock, 1992; Good, 1994; Littlewood, 1995; McElroy & Townsend, 1996; Rait & Burns, 1997). This perspective emphasizes that mental health problems are the product of both biological and social elements (Helman, 2000) and that their meanings are communicated in a culture-specific way (Estroff et al., 1991). Advocates of this perspective argue that mental distress is "culture-bound" (Dresslers, 1990); therefore, its symptoms and treatments are not universal and homogeneous. Mental distress is therefore unique to a particular group of people, culture, or geographical area, and changes along with time, particular context, and within a specific cultural space.

For example, the symptoms and treatments of *unmāda* (meaning severe mental disorder), in India have undergone changes from classical to present day India (Weiss et al., 1986). In the classic Indian period, *unmāda* was defined as demonic possession, evidence of violation of taboo, or a result of intense stressors interpreted according to a humoral paradigm. People suffering from distress were treated or cured with food offerings, chanted *mantras,* and trance. Today in India, different conceptual models are available to interpret the nature of the affliction, and alternative treatments are available to relieve distress including allopathic psychiatric services, Āyurvedic practitioners and homeopaths, and various folk practitioners and healing temples (Kakar, 1982).

Furthermore, from a cultural relativistic perspective, Fenton and Sadiq-Sangster (1996) emphasize that an individual's perception of mental distress or experience of "madness" (Foucault, 1965) is not independent of cultural history, but very much connected to it. In most cases, this "meaning centered approach" (Acharya, 1996) has assisted victims in defining and responding to mental health problems according to their personal and cultural symbols, values and norms. This approach was not extensively utilized in ethnogerentopsychiatry research until the 1980s[64] (Hughes, 1990; Sperber, 1996; Gutmann, 1997) and did not take a central role in research on the mental health of

[64] Kakar (1982) in his ethnographic study of mental disorder among Indian psychiatric patients found that persons who used or were brought to temples by their families for relief of demonic possession were mostly girls and young women. As this study focused on Indian psychiatric treatment methods, it is unclear how older women in India view and manage mental distress. See *Shamans, Mystics & Doctors* by Kakar.

elderly women until the 1990s (Stenchever, 1996; Allen & Phillips, 1997; Bonita, 1998).

Most health research and feminist writing have given much attention to the ways in which mental health problems are recognized, labeled, explained and managed by sufferers, their family members and community (Furham, 1994; Ananthanarayan, 1996; Gutmann, 1997; Shirali, 1998; Schreiber, 2000; Davis, 2000). Researchers have primarily examined the perception and response to mental disorders (Livingston et al., 2003) including depression (Lee et al., 1995; Antai-Ontong, 1997; Louie, 1998; Aroian & Norris, 2000; Livingston & Sembhi, 2001), anxiety disorders (Richardson, 2001), and post-traumatic stress disorder (Ta et al., 1996; Davis, 2000) across the lifespan of VMW. These studies overlook the *social* meaning of mental distress among VMW, including elderly EIIW. In the past decade, cross-cultural health researchers have argued that to prevent and control the rise in psychological disorders it is essential to hear people's voices about mental distress in a health promotion setting (Adams & Williams, 1995; Majumdar et al., 1999; Davar, 1999). For example, Varghese (1976) argues that "Good health is in a person's mind" (p. 215), and that emphasis should be placed on understanding why some people define mental distress as they do and how they decide their help-seeking behavior over their lifecourse.

Studying mental distress as a disease or illness is an important medical/health issue. According to the western psychiatric perspective, diagnosing treated and untreated psychological disorder cases (Shah, 1968; Varghese, 1976; Marsella, 1978) is crucial for intervention and treatment of a high risk population such as women (Dresseler, 1990; Majumdar et al., 1999; Helman, 2000; Richardson, 2001). From a cross-cultural perspective, these studies show the similarities and differences in defining and managing psychotic disorders among men and women across cultures. For instance, Schreiber et al. (2000), in a qualitative study of depression among Black West-Indian Canadian women found that these women managed depression in culturally defined ways by "being strong" (p. 39). Psychoanalytic feminists, sometimes known as cultural feminists (Phillips, 2000), consider this behavior a feminine response strategy to depression or other life threatening stressors (Bromberger & Matthews, 1996; Taylor et al., 2000).

This body of literature, while making significant contributions to our cultural understanding of how psychiatric disorders among VMW are shaped, brings with it, and reinforces, several western stereotypes about VMW's expression of mental distress. These stereotypes, Krause (1989) and Helman (2000) argue, are derived from biomedical psychiatric diagnostic categories and western medical/health professional bias and include three popular cross-cultural assumptions about how VMW cope with depressive disorder and distress: somatization, familialism and silence.

Somatization: Clinical Manifestation

The first stereotype suggests that VMW explain mental distress and its symptoms in somatic terms. Following this generalized "speaking with body" (Helman, 2000), western mental health researchers tend to describe VMW as passive and powerless to expose their personal and interpersonal problems (Meleis & Hattar-Pollara, 1995; Holmes & Holmes, 1995; Yee, 1997). Kleinman (1995), who has extensively studied the behavior of non-western psychiatric patients, suggest that somatization is extremely common among Chinese people.

This universalistic and generalized position is useful since it describes a general trend among VM psychiatric or ex-psychiatric patients, however, it fails to provide rich contextual details of elderly VMIW's distress coping behavior. In particular, the distress behavior of aging EIIW remains unexplored (Guha, 1992; Shirali, 1998; Lamb, 2000).

Krause (1989) argues that somatization of mental disorders does not necessarily mean that these women do not understand distress. Krause illustrates in her study of Punjabi women living in Bedford, England, her informants' integration of the signs and symptoms of depressive disorder into Punjabi culture and Punjabi society in Britain. The Punjabi women in this study express personal emotional distress in a somatic idiom such as a "sinking heart." They link feelings of anxiety with physical sensation in the heart or chest, and they think the symptoms are caused by heat, anger, exhaustion, worry, or social failure. Krause's findings resemble the western psychiatric diagnostic categories; however, she does not fully adhere to the "mind-body" view of western medicine and sees the Punjabi British women's expression of distress as a by-product of western and Indian humoral paradigms.

Fenton and Sadiq-Sangster (1996) explore the cultural expression of mental distress among South Asian women from the Pakistan-India border living in Britain. Using quantitative and qualitative data from two studies carried out in Bristol, the researchers illustrate that, although there are variations in interpretation of mental illness syndromes, the participants have a clear conception of mental health and make important distinctions between types of mental illness. In this study South Asian women describe mental distress using a culturally specific set of language terms, and their accounts differ from those of English-speaking British people. They describe syndromes of mental distress that correspond in many ways to the category "major depression". Attempting to demonstrate diversity among South Asian women, Fenton and Sadiq-Sangster focus on participants' use of language and symbolism to express both physical and mental distress. They warn future researchers to interpret findings cautiously and not generalize across all women with the same ethnic ancestry.

Pang (1994), in a qualitative study of twenty-four mostly female elderly Korean immigrants residing in Washington, DC, explored their understanding of depression. Pang found that his informants related depression to emotion and mind (mood), but not as a serious physical illness except when it was related to folk illnesses. These individuals did not associate physical complaints with depression. Instead, they saw depression as subject to control by the will. As one remarked, "You can control depression. You can express it, or you can keep it to yourself" (p. 212). Kim (1987) provides another example of elderly Korean Canadians' cultural practice of not talking about the experience of isolation, anxiety or depression. Further, Kim argues that Korean people somatize not out of powerlessness, but to avoid the stigma attached to mental illness. In short, VM sufferers and non-English speaking elderly immigrants and women use somatization as a strategy to communicate with others. Somatization serves as a process for healing, allowing sufferers to release expressions, admit problems, and adhere to treatment (Bartholomew, 1995).

Mental Distress and Familialism

The family is important to aging VMI communities from non-western nations. The distinction between immediate and extended family is virtually nonexistent (Meleis

& Hattar-Pollara, 1995; Holmes & Holmes, 1996; Luborsky & Rubinstein, 1997). Many western studies have documented the overriding importance of joint family, extended family, intergenerational ties, links to home and place of origin among this group of people and levels of depression and distress (Bernardez, 1984; Halperin, 1990; Guzder, 1992; Bagely, 1992; Lee et al., 1995; McElroy & Townsend, 1996) and suicide risk (Hu, 1995; Cattell, 2000).

Yee (1997) demonstrated that for elderly Cambodian women residing in the United States, giving up the tradition of intergeneration co-residence or taking care of one's parents in old age has led many to experience emotional strain. Furthermore, Yee noted that psychological strain became acute when these women experienced abuse from young members in their families. One informant indicated that, as a mother and grandmother, she was expected to provide childcare and household tasks for her son's family, but was not welcome to live with them. Furthermore, lack of respect from her American-born teenage granddaughter made her think of suicide as the only solution to her situation. This study confirmed findings from earlier studies that lack of respect from children and grandchildren leads to psychological distress among elderly VMIs (Climo, 1990; Desai, 1992; Hall, 1993; daCosta, 1993; Leung 1996).

True (1995), in a critical review of the literature of Asian and Pacific (A/PI) women, argues that A/PI women are reared and socialized to sacrifice their own personal needs to the needs of their men and children. This cultural psycholization or "learned behavior," some anthropological and qualitative gender researchers (Shenk, 1990; Guzder, 1992; Keith, 1993; Osgood & Malkin, 1997) argue, is carried over by many ethnic minority women into old age, making them more prone than men to mental distress and depression.

While most studies have focused on the negative aspects of families, a few recent studies have begun investigating the accommodating approach, showing that some changes have occurred in the South Asian communities' family structure. Dossa (1994) in an anthropological study of Ismaili elders from Africa living in Canada shows that a large number of elderly parents live in nuclear families. In a community whose cultural identity is associated with extended family, this living arrangement may seem a practice

of individualism to western eyes and the culturally informed. It may also represent acculturation and integration to the dominant Canadian culture. Dossa argues that this living arrangement provides the elderly with tangible space, however untraditional, to maintain their social and symbolic status as matriarchs and patriarchs. It also removes their anxiety about being a burden on adult children, which sometimes develops among members of immigrant groups in a new culture. It is unclear from Dossa's study if single elderly Ismaili women psychologically adjust better in an independent living arrangement.

In a British survey of the mental health of elderly Asians in Britain, Guglani, Coleman and Sonuga-Barke (2000) observed that grandmothers living in British Hindu communities have better psychological adjustment in extended families compared with those living in nuclear families. In this study, grandmothers had more positive mental health when their granddaughters considered themselves to be Asian, Indian, or Hindu both in nuclear and extended families than those whose granddaughters considered themselves to be British (p. 1051). The authors caution that theirs is a preliminary study with small sample sizes; they encourage future researchers to study mental health in the context of families more holistically and not only from a negative perspective. Most Asian studies specialists and gerontologists acknowledge that there have been fundamental changes in some aspects of Asian families including a shift from living in extended to nuclear families. Nonetheless, Guglani, Coleman and Sonuga-Barke argue that the Indian family's moral sense of obligation to family members is an important therapeutic resource that has helped Asian families to adjust or remediate life adjustment problems, regardless of their actual living structure. However, research has not yet investigated whether performing familial duty in the context of changing family structure is beneficial to elderly EIIW's sense of wellbeing.

Mental Distress Means Silence

Excessive attention has been paid, particularly in the ethnic minority women's psychocultural literature, to silence, compliance, family honor and cultural identity (Naidoo, 1992; Malone, 1993; Leung, 1996; Lee et al., 1996; Gutmann, 1997; Levin et al., 1998). For instance, Sue (1994), an expert in psychoanalysis, contends that to protect

family honor from cultural stigma many members of ethnic minority groups do not disclose their mental health problems and defer seeking professional health services. This behavior, she argues, has contributed to family members experiencing psychological distress at home for longer periods and presenting them for hospitalization at a more advanced stage of illness. Fenton and Sadiq-Sangster (1996), studying British South Asian immigrant women, argue that although these women recognize mental distress, they believe it an illness for which there is no medical cure. From an Indian cultural perspective, Shirali (1998) believes that Indian women provide such explanations to avoid blame. Indian women's sense of *Sharam* (a cross between shame and shyness) seems to have its locale in the body, for which they do not seek help. Shirali links silence with compliance, arguing that Indian women are socialized either to feel guilty or to blame their karmic fate and hate themselves for the illness. Women in India are represented as nurturant, emotional, sexual and physical service providers. Expressing mental distress means they are unproductive, worthless and unable to fulfill their role; consequently they are rejected by family members or locked up in an asylum.

Family honor theorists see the practice of silence in India as violence against women, exploitation and sexism. Identity theorists describe silence as a *resource* to deal with illness prevention and management, and development of a healthy self. The most definitive work in the area of mental distress and resistance is that of Indian cultural feminist Davar, *Mental Health of Indian Women: a Feminist Agenda*. Davar argues that, despite sustained efforts by scientific pundits to understand mental distress from a psychotherapy point of view, cultural expressions of mental experiences are still practiced by many EIW in India. Davar asserts that women consciously carry out this behavior for their psychological benefit, including a sense of wellbeing and peace. Many do so to restructure or sustain their position and avoid showing vulnerability to major depression (Chakraborty, 1990; Sandhya, 1994; Meleis & Hattar-Pollar, 1995; Schreiber et al., 1998). Therefore, advocates of culture suggest that, just as attitude towards mental distress is explainable from within the epistemic construction of the experiential approach, "adaptive strategies" followed by women are explainable in terms of power and control.

The "control" ideology (Shirali, 1998) does not adhere to the structuralist's view of the privileged group or western patriarchy, but to the internal strength of the individual or group of women who are buried in the discourses of Indian femininity and patriarchy. Assessing Indian women's healing strategies, Shirali pointed out that, in India, women follow ingenious ways of healing. While some women have found the "secret mantra", the healing idiom, others follow "trance" or "possession" behavior. Kakar (1982) observed similar coping strategies in an earlier anthropological study. Through possession, Shirali argues, women radically transform both their disease and their social garb of passivity for the wellbeing of their real holistic selves. More importantly, they turn their helplessness and powerlessness, which come with socially achieved status and role, inside out into fearsome visages of "shakti" (power) and the "supernatural" (p. 69). In short, through this process women empower themselves within problematic social circumstances. Davar (1999) describes possession as a strategy used by many lower-caste women in India to manipulate the hierarchical and discriminatory cultural system.

Critical Evaluation of Cultural Explanations

These studies help to explain the interaction between psychology and cultural tradition of women. Psychocultural theorists, anthropologists, sociologists and feminists (Meleis & Hattar-Pollara, 1995; Gutmann, 1997; Shirali, 1998; Davar, 1999) argue that social relations are both the great teachers of human life and a major deterrent to individuals' physical and mental health. A few studies have attempted to clear the gender/sex bias that is inherent in mental health cross-cultural studies pertaining to somatization, familialism and silence.

Cultural explanations of aging and mental distress among VMW that were developed by western scientists (Marsella, 1978; Littlewood, 1995; Holmes & Holmes, 1995) are frequently criticized for being Eurocentric. For instance, VM women who are viewed as westernized are mostly removed from these types of research in western countries. When and if researched they are often illustrated as healthy individuals because of their acculturation to western culture (Patel, 1983; Burr, 1992; Bassi, 1995; Mehta, 1998). Thus psychoculturalists commonly maintain the explanations under the single concept of acculturation, without suggesting how women have used the concept of

acculturation within their life course. Nor have they placed the voice of elderly individuals at the centre stage of cross-cultural mental distress research.

Another related criticism addresses the imperialist attitudes and practices of social and human population health scientists. Advocates of plurality and diversity (also known as post-modernists) suggest that by focusing on a single unified concept such as culture, researchers tend to assume that culture is intrinsic, ignoring the aspects of diversity and change. Like the race and ethnic theorists, culturalists tend to focus on the marginalized. In the case of elderly VMIW, most studies have focused on the non-English speaking population, new immigrants, refugees and the elderly VM population, and then generalize to the entire VMW populations. For instance, most South Asian psychological distress studies have used samples of Indians who speak mainly Hindi, Urdu or Punjabi, are new immigrants, and are primarily men (Mays, 1983; Atkin, 1989; Boneham, 1989; Bassi, 1995; Williams et al., 1997; Bhatnagar & Frank, 1997; Silveira & Ebrahim, 1998; Jan & Smith, 1998; Guglani et al., 2000; Livingston et al., 2003). Although these studies have made significant contributions by studying specific linguistic groups of Indians, cross-cultural researchers risk misinterpretation of data, bias, and at times oversight of potential health care needs. Earlier studies warned that there are no exact Indian terminologies to describe western mental health syndromes (Kakar, 1982; Weiss et al., 1986; Krause, 1989). Most recent studies in India have indicated that elders from urban centers and retired upper socioeconomic class families believe in and practice Indian tradition to cope with psychological distress in old age (Srivastava, 1994; Yadava et al., 1997; Gurumurthy, 1998).

Third World feminists such as Mohanty (1991) and Bhattacharjee (1997) refer to this as mainstream feminist discrimination, but it may also be scientific imperialist practice. So far, researchers have excluded those whom they perceive as difficult to access, like themselves, or people who may question them (Ironstone-Catterall, 1998). These scholarly imperialist practices may have contributed to the paucity of information on how linguistically assimilated elderly EIIW, the least studied group (William et al., 1997) define the social non-clinical meaning of mental distress in old age. How do they respond to the perceived threat of mental distress? The following section addresses the themes identified here, illustrating their significance for the study of the construction and

coping strategies of mental distress among elderly EIIW living in Canada.

II. Symbolic Interactionism: Interactional Approach to Knowledge Construction

The symbolic interaction paradigm is rooted in Mead's (1934) ideas on pragmatism and social behaviorism. Early symbolic interactionists such as Mead and later on Blumer (1969) believed that there is no objective reality. They argue that individuals or groups actively create an object for the benefit of human society as a whole. People are conscious actors and give meaning to the object based on their perception, knowledge and experience. The second tenet of symbolic interactionism is that the meaning associated with the object(s) is fluid. As Blumer (1969) suggests, meaning changes in different social situations and is based on ongoing social interaction. Blumer's third proposition is that the object is something that is designated. It can become the *agent* for social change (Blumer, 1990). Thus, one can organize one's action towards it, instead of responding immediately to it. People act toward objects on the basis of the meaning the objects have for them (Acharya, 1996). The concept of the socially constructed *object* is now an important pillar in the study of both social interactions and social change. Charon (1992) explains:

> Symbolic interactionism is a perspective that differs from the typical natural and social-scientific perspectives of the human being. Instead of describing the human being as a stable personality caused by what happened in the past (nature or nurture), the human being is "emergent," always changing as he or she deals with situations encountered. The human being is social, symbolic, and mental, rather than simply a physical entity. (p. 34)

Symbolic interactionism is essentially a social-psychology perspective (Karp, 1994; Plummer, 1996; Wallace & Wolfe, 1999; Ritzer, 2000) where people reflect, interpret a situation or events, and share meaning. In this specific context I hope to make a contribution, for recent ethnogerontological and mental heath research shows that there is considerable diversity within the elderly VM population. There has been much debate as to whether immigration, race, ethnicity and culture cause or prevent mental distress. Very few studies have attempted to address this point among elderly VMIW through their life experiences (Dossa, 1994; Deepen-Wood et al., 2000; Bernard et al., 2000). This

forms the basis for my study and choice of conceptual paradigm. As Denzin (1997) suggests, understanding that human beings' elaborate symbol-producing capacity also enables them to produce a history, a culture and an intricate web of communication has made symbolic interactionism one of the most enduring social theories for the twenty-first century. Therefore, four major ideas of symbolic interactionism deserve further elaboration for the study of mental distress among aging Canadian EIIW.

As mentioned earlier, the most important of the three ideas of classical symbolic interactionism is emphasis on studying social interaction. Therefore, in the world of the interactionist, human beings are creators of social order and organization, rather than passive members of a society or culture who are influenced by others – "To some extent they are in control of their own evolution" (Charon, 1992). Based on this philosophy, Littlewood (1995) notes, much of the work on mental health problems including his own has focused on the task of developing a perspective on the subjective and goal pursing actor. This type of mental health research has led to the question of the origin and nature of mental distress and to questions about what propels or constrains human actors in handling, modifying and transforming their perception, behavior and lives. The emphasis is on understanding the inner meaning that individuals as a collective attach to mental distress and its outcome.

Wolff and others (1996) in their cross-cultural community mental health study found that people who were aged, with little education, and belonging to the VM group such as Asian Indians were less likely to be able to name correctly at least two mental illnesses. People who did not suffer from a mental health problem or did not know anybody who had suffered from this ailment were less likely than other people to name two mental disorders correctly. Interestingly, these researchers identified a widespread belief among Asian Indians that mentally ill people are more intelligent than others. This notion may have its root in Indian folk reasoning about mental distress (Nunely, 1996; Charkraborty, 1990; Kakar, 1982). Further analysis is required to learn why they believe this way and its consequence.

Central to the analysis of the question "why" is the issue of meaning. The symbolic interaction approach links individual and group perception. Interactionists

would concur with other social and feminist theorists in asserting that meanings are the product of people's perception and experience. In Mead's theory (1934) perception is the second stage of the *act*, where more general cognitive evaluation, negotiation and adjustment take place. At this level the action begins, and the actor uses both incoming stimuli and the mind in the creation of mental images, characters or an object for the stimulation (Plummer, 1996; Blumer, 1995). It follows that thinking or perception is not fixed or immutable. Blumer (1995) describes it as a dynamic, continuous process that assists the actor in defining a situation for the present or future. Therefore, perception is open to interpretation (definition) and reinterpretation (redefinition), and prepares the actor for social action; hence, "typification", "naming" and "categorization" are vital to providing symbolic meanings to one's self, to others, and to the social world (Ritzer, 2000).

In most cases, interaction theorists argue that perception is an internal conversation that constantly goes on in an actor after social interaction in human society. Besides, the object constructed for the human being is constantly being tried out in situations and is being judged by its usefulness. In short, perception and object cannot be separated from one another (Ritzer, 2000). Perception is built, produced or evolved through socialization, communication and reflection; it is a very active view of human beings and their social world. Therefore, Jaffe and Miller explain:

> Central to the interpretive process of social actors is the creation of meaning.....The meanings we claim as our own are like cognitive and moral lenses. They present a framework that provides understandings for objects, acts, gestures, and words. Meaning creation is social. It emerges through social interaction. (1993, p. 53)

The third valuable aspect of symbolic interactionism is studying social action. Here, the focus of all interactionists is to understand how human personal and collective knowledge is developed through social action (Acharya, 1996). This focus on collective behavior (Plummer, 1996), is called "taking others into account" by Blumer (1969). Functional theorists are often concerned with reducing human beings to a set of structures, functions and mechanisms whose purpose is to keep society homeostatic and orderly, static and conventional. Symbolic interactionism helps with illustrating the "joint action" through which lives are organized and societies are assembled. Blumer argues

that to achieve this social process and to satisfy the original idea (hypothesis), people think and often use manipulation and consummation. These strategies are also key symbols that signal the oncoming acts, behavior or attitudes of the actors (Ritzer, 2000). Although interactionism acknowledges that almost all behavior is symbolic to some extent, it is not separate from mind. Behavior is a social interactional process conducted by means of significant symbols (such as talk or language) and gestures (Blumer, 1995). Thus, Charon (1992) explains:

> Social action tells people who we are and what we think – our ideas, perspectives, wants, motives, intention, morals, background, strengths, and dislikes. Social action therefore means that other people are very important to what we do. (p. 145)

Symbolic interactionism emphasizes that social interaction is mutual; involves personal identity, status position, role taking, cultural values and norms, and labeling others; and influences others' identity (Charon, 1992; Blumer, 1995; Acharya, 1996). Ritzer (2000) argues that interactionists should focus on culture through a critical approach. Sociologists such as Denzin (1992) have urged interactionists to focus more particularly on communication technologies (such as talk, text and gesture) and technological apparatuses (history, personal and cultural points) and the way in which they produce reality and representations of that reality (the politics of representation). Denzin suggests paying attention to three interrelated problems: "the production of cultural meaning, the textual analysis of these meanings, and the study of lived cultures and lived experiences" (p. 34). This study will not exclusively follow Denzin's cultural analysis, but will embed perception, appreciation and actions. Bourdieu (1977) has called these "habitus," Silverman (1985) used the term "cultural particulars," and Swidler (1985) used the concept of a "cultural tool kit" from which individuals have the opportunity to select material when constructing social reality. These concepts are useful when I attempt to characterize EIIW elders' social choices and folk theories of choices to describe mental distress and coping strategies, since these are undiscussed topics for many in their everyday lives.

The combination of high-risk environments and multicultural societies has forced symbolic interaction theorists to engage specifically in empirical research. The interactionists' abiding concern with how meaning is constructed in and through

everyday interaction (or group life), the theory of interaction, and the creation of political awareness of the need for amelioration of problems have all contributed to the popularity of qualitative research methodology. This inductive approach (Wallace & Wolf, 1999), the fourth theme of symbolic interactionism, has led to numerous life experience studies of elderly VMIs (Majumdar, 1993; Dossa, 1994; King, 1995; Berg, 1998) and to some ethnogerontofeminist research (Yee, 1997; Deepen-Wood et al., 2000; Chambers, 2000). This subjectivist approach makes symbolic interactionism not only a "down-to-earth" paradigm, but it allows analysts to understand the inner or "experiential" aspects of human behavior, as these relate to human social behavior and beliefs (Chenitz & Swanson, 1986). This last point is especially important to my research in helping me better address elderly EIIW's explanations that have their roots in historical, personal and experiential reality. As suggested earlier, for symbolic interactionists, meaning or "reality" (Chenitz & Swanson, 1986) guides behavior, and a definition of the situation precedes action (Reutter, 1991). The following chapter outlines the methodological approach, sources of data and modes of analysis utilized in this research project.

CHAPTER FOUR

THE PATH FOR UNDERSTANDING MENTAL DISTRESS AND HEALING PRACTICES AMONG EAST INDIAN ELDERLY IMMIGRANT WOMEN: A CANADIAN CONTEXT

> Qualitative analysis does not draw on a large, well-established body of formal knowledge from mathematics and statistics. The data are in the form of words, which are relatively imprecise, diffuse, and context-based, and can have more than one meaning. (Neuman, 1997, p. 420)

Recognizing the limitations of cross-cultural geropsychiatry research in North America (Gutmann, 1997; Maxwell & Oakly, 1998), and the under-representation of qualitative studies in the field of gerontology (Haldemann, 1993; Abel & Sankar, 1995; Clarke, 2000), Henderson (1994) argues that qualitative research is beneficial in studies of ethnic-minority life experience, especially in the context of elder subjects. Qualitative research may at times look chaotic, but it leads the researcher to issues that have not been conceptualized or approached in traditional social science research. This chapter describes a qualitative approach to exploring mental distress among aged EIIW.

The chapter is divided into four sections. The first draws a methodological map of the study, explaining the choices made and the rationale for using certain procedures in the collection, discussion and analysis of data. Initially, this section focuses on the reasons for "adapting" (Glaser, 1999) a case study approach, followed by case selection and ethical considerations. The second section deals with data collection strategies. The third section discusses procedures for data analysis. The chapter ends with the demographic descriptions of the participants under study. The chapter lays the foundation for the interpretive analysis to be carried out in ensuing chapters (Charmaz, 1990; Gubrium, 1992; Kaufman, 1994a, b; Brink, 1994; Marshall, 1996; Hendricks, 1996; Jamieson et al., 1997; Denzin, 1997; Stake, 2000; Davis, 2000; Abraham, 2000; Herzfeld, 2001).

I. Research Design[65]

A. Qualitative Inquiry: Indepth Analysis

The Case Study Approach

The qualitative approach proposed here is designed as an exploratory study to improve our understanding of mental distress among aged EIIW in Canada. Holstein (1995) suggests that an individual's understanding of mental distress occurs in specific situational contexts and places in which "The individual's search for meaning both influences and is influenced by cultural values" (p.114). In the context of this cultural conceptual framework, the exploratory questions and the lack of ethnogerontofeminist and qualitative studies on mental distress[66] among English-speaking elderly EIIW led me to conduct a qualitative study, specifically a Canadian study using the case study approach. There are other reasons for the case study approach.

Case Study Helps Focus on the Specificity of the Case: A case study approach allows the researcher to gather specific information about an issue/issues, case/cases, event, community or people within a specific culture, time and place (Reinharz, 1992; Berg, 1998; Stake, 2000). More important, case study allows the researcher time and opportunity to access and investigate complex issues, and to explore commonality of experience, value and practice that have been often overlooked in traditional research. For example, to date, South Asian psychological distress studies have excluded explanations of how EIIW conceptually categorize common emotional problems in old age. To explore the meaning of mental distress and its symptoms among aging EIIW in Canada, a case study approach is needed. So far, this group has been omitted not only in cross-cultural mental health studies but also in cross-cultural and psychofeminist studies. Second, sociological and cross-cultural understanding of elderly EIIW distress coping strategies is clarified through this approach.

Case Study Uses Multiple Information Sources: There is substantial controversy relating to whether case study is a method or an approach. Some qualitative researchers

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[65] Please see Figure 3.

[66] Previous studies have mostly used survey methods (Gupta, 1991; Rait & Burns, 1997; Ananthanaryanan & Cochrane, 1999); focus group research (Ahmed & Webb-Johnson, 1995); and anthropological approaches such as ethnographic studies (Kakar, 1982; Chan, 1987; Boneham, 1989; Dossa, 1994).

believe that case study is an approach because a variety of data gathering techniques are employed to collect rich data. Rich data gathering techniques can include in-depth interviews, observations, life histories, stories, documents or oral histories (Reinharz, 1992; Ironstone-Catterall, 1998; Berg, 1998; Clarke, 1999). The proponents of the case study approach argue that, since the goal of the researcher is to analyze an issue and find out how it operates or functions from a sociological perspective, it is appropriate to refer to case study as an approach. For Babbie and Benaquisto (2002), "It is a design of research study" (p. 308) which includes what unit to focus upon, what data collection strategies to utilize, and what type of study it is. In this context, the issue is mental distress; the unit of study is English speaking elderly EIIW; and the data collection methods used are indepth interviews, observations, field notes and secondary documents.

Case Study Investigates a Phenomenon for Theory Building: A case study can be intrinsic (studying a particular case), instrumental (used to study an issue or refine some theoretical explanation), or collective (extensive study of several instrumental cases) (Stake, 2000). While intrinsic case study develops mostly from the researcher's specific interest in the case per se, instrumental case study examines a particular case to provide insight into an issue or redraw a generalization (Stake, 2000). Although some believe the differences between intrinsic, instrumental and collective case studies are blurred (Berg, 1998; Stake, 2000), this research is collective, involving a number of instrumental case studies. The findings from ordinary English-speaking elderly EIIW living in Edmonton, Alberta, Canada facilitate an understanding of mental distress in general. Here, the notion of generality indicates that the findings will provide a better understanding of how elderly EIIW define mental distress while aging in Canada. More importantly, this approach is adopted in order to gain an in-depth understanding of the construction and management of mental distress among elderly English-speaking Canadian EIIW, a group that has been overlooked in ethnogerontopsychiatry studies.

Case Selection: Research Site

Currently the largest number of elderly EII reside in Edmonton, compared with other urban locations in Alberta (Statistics Canada, 1998). This information helped to narrow my choice of the case study to the Edmonton metropolitan area. Although a

significant number of EII elders live in this community, no qualitative research on mental distress has been undertaken on the English-speaking EIIW population. Specifically, very little is known about how EIIW elders understand and deal with mental distress, at a time when the Alberta Mental Health Board states that "One in five Albertans will experience mental illness sometime in their lifetime" (Alberta Mental Health Board, June 3, 1999, p. A9). Accessibility was another reason for selecting Edmonton. The EII community was supportive of this study and several Indo-Canadian community leaders facilitated access on my behalf.

B. Methods for Selection of Cases for Interview

Negotiating and Gaining Access to Local Indo-Canadian Community Associations

Every field researcher confronts the challenge of how to access and select good cases. Selection of proper cases may be difficult for a researcher studying any ethnic minority population (Henderson et al., 1992; Henderson, 1994) such as the EIIs, particularly on the issue of psychological problems (Naidoo, 1992; Bhui et al., 1998). Acknowledging this research challenge, and being a non-resident of Edmonton and unfamiliar with the EII community in the Edmonton metropolitan area, led me to depend on networking. This networking began with contact with several Indo Canadian community agencies.

In July 2000, I made informal personal contact with an Indo-Canadian Women's Association and two Indo-Canadian Community Associations for retired people. I learned that these organizations were the only community-based associations providing services and programs specifically for EII elders in Edmonton. I was informed that in these centers many EI elders meet weekly to socialize, celebrate their religious festivals[67], speak in their own language, share stories from their homeland, play games and eat their traditional food. I was told that these associations would be the ideal places to gain varied EIIW names, a non-probabilistic (Wackerbarth, 1999; Thompson, 1999) convenience sample as there is no formal list of names available of the population. In order to solicit potential participants who might offer opportunity to learn (Stake, 2000), these

[67] India is a country with many religions, languages and cultures. Although the East Indian immigrants may come from a diverse background, they have come primarily from an agrarian society (Pillai, 1985).

associations became my first point of entry to the community. To continue building the network and to solicit individuals who are cooperative, have rapport, and above all are suitable for the informational needs of the study (Luborsky & Rubinstein, 1995), it was important to build a rapport with the association leaders. In order to achieve this objective, and to recruit individuals who are articulate, reflective and willing to share sufficient information on the selected topic (Morse, 1991; Brink, 1991), I engaged in networking.

Networking: The initial networking with the Indo-Canadian community organizations was particularly constructive when I was invited by the past Vice-President[68] of the Indo Canadian Women's Association to attend on September 25, 2000 an Advisory Committee meeting for the forthcoming seniors' conference entitled "Growing Old in a New Country." I was invited to make a formal presentation of my doctoral dissertation research project. To enhance my contact with, support by, and cooperation from the Indo-Canadian community leaders, I accepted the invitation and made a brief presentation to the Advisory Committee members[69]. Upon recommendation, I became a member of the Advisory Committee for the seniors' conference to be held November 5, 2000, as well as a member of the Indo Canadian Women's Association.

This networking helped me obtain knowledgeable participants for the study. The Indo-Canadian Association directors helped to overcome access barriers to the study group involving language competency, age, participants' place of origin, family dynamic, and willingness to discuss, providing a diverse sample. Brink (1991) recommends that it is wise to use panel of experts or a "judge panel" who will help to establish a purposive sample for the study. Often researchers do not have enough time and opportunity to assess a participant's suitability in an unfamiliar environment (Morse, 1991; Bernard, 1994; Lamb, 2000), and inhospitable participants may not provide needed information

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[68] I would like to specially thank Mrs. Geeta Das, past Vice-President and board member of the Indo Canadian Women's Association, for her support and cooperation in the networking process with local Indo Canadian community associations involving my contact, identification and access to potential aged EIIW participants.

[69] This committee included representatives from several Indo-Canadian linguistic groups, Heritage Canada, Alberta Aging, Immigrant Settlement Association, Image India, Muslim Association and a social worker from the Grey Nuns Hospital mental health program.

(Stake, 2000). The Indo-Canadian community leaders of Edmonton assisted me in the sample selection.

Recruitment of Research Cases: With the assistance of well-informed local elderly Indo-Canadian Association experts, who were able to recommend individuals who would be good to talk to, easy to access, and willing to participate, a purposive and snow ball sampling for this study was initiated. Pre-interview invitation letters were sent to elderly EIIW (see Appendix B), between the ages of 60 and 74, who were living in their home in the Edmonton metropolitan area. The letters invited them to participate in mental distress research. To further facilitate the selection procedure, the letters extended the invitation to women who had immigrated from India, lived in Canada ten years or more, and could converse in English.

Characteristics that are likely to provide a comprehensive understanding of the mental distress process guided the initial selection of participants. Age, place of birth, length of stay in Canada, and language were used in the selection of appropriate participants. EIIW elders were interviewed in order "to maintain homogeneity and comparability within the sample as an aid to identifying similarities and differences" (Luborsky & Rubinstein, 1995, p. 107). Similarly, only EIIW who have lived in Canada for 10 years or more were included. A recent study has proposed that the longer immigrants live in Canada, the more they experience health problems similar to those of Canadian-born citizens (Statistics Canada, 1996a). Therefore length of stay is an indicator of a change in life pattern of EIIW elders and experience of mental distress. Finally, participants able to converse in English were invited to participate. Although 85% of EIIs can carry on a conversation in English (Statistics Canada, 1996b, p. 5), no studies could be found that describe how elderly EIIW in Canada describe the western concept of mental distress and its symptoms in English.

My telephone contact numbers were provided to each of the community leaders and potential participants. This protected participants' identities, ensuring that others in the community would not know that these individuals were participants unless they themselves chose to disclose this information. The community association leaders provided me with seventeen participants' names and telephone numbers. At the end of

each interview, the participant was asked if the interview was threatening in any way or invasive into her personal life. They were also asked if they thought participation in this research project might encourage other elderly EIIW to share their experience with me. If the response was positive, they were requested to find more immigrant friends or family members from India for this research project. If any participant agreed to do so, a few pre-interview invitation letters and instructions were left for them to contact me. This sampling strategy (i.e. ongoing recruitment of participants) yielded over thirty female names in the first two months of data collection[70]. The following samples of soliciting comments used by research participants to their friends were recorded with permission in my presence after the termination of the interview:

> Wait! Wait! I will ask a friend of mine. [Telephone call] Hello, xxx, this is xxx. I have a student[71] from the University of Alberta, sociology department who is talking to elderly EIIW about her research. I just finished mine. She is from our country and is doing her Ph.D. Can you talk to her?
>
> She is very nice. She is a Brahmin[72] too!
>
> I told my friend. She helped me. She will help you from your pain.
>
> This lady is here. She is a student who is doing research for her thesis. She is here and can go up and interview you.

Such comments showed that, for the most part, it was very important for the elderly participants to recognize my social, political and cultural links with them. My identity as a researcher, student, and EIIW of a certain age was constantly manipulated during the data collection period. In the context of power relationships between the dominant (researcher) and the subordinate (subjects) parties, most elderly EIIW participants viewed me as a young female researcher, a student, from India, someone who

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[70] After hearing and reading about my study, five elderly men approached me to include them in the research project.

[71] Both formal and informal categories were applied by each participant to frame my "identity" and "status" in their social environment.

[72] In the Hindu (also Indian) caste system (also called as "Varna" system) Brahmans belong to the highest caste, followed by Khatriyas, Viashyas and Sudras.

would understand their stories and experiences and possibly help the women in their community in Canada and abroad in some ways. I occupied a complex social status that is indicative of "hegemonic power relationships that undergird the research processes" (Standfield II, 1993, p. 32). It seems I was recognized as a "collaborator" (Ironstone-Catterall, et al., 1998), as measured by birth rank, social mores, education, political clout, and the racist, classist and sexist history of EIIW in Canada (Bannerji, 1993; Thobani, 1999). Thus, I occupied the position of a "child" (a subordinate status). According to the normative Indian life stages or the theory of duties, I was viewed as a "student" (in Sanskrit, brahmacharini)[73]; and from a sociopolitical stand point a "researcher" (dominant status) and a "partner" (Chappell, 1995) with "visible minority immigrant women" (Bannerji, 1991), who is studying an excluded and marginalized group, "the ethnic minority aged women" (Zhan, 1998). This construction of multiple identities by the participants was unexpected; however, it seemed a positive response by the participants and facilitated the completion of the sample selection. It illustrated the willingness of the participants to talk and share their stories with others, but with an invisible face. There is pressure to guard the privacy of these individuals. This ethical consideration is critical for all researchers who are dealing with human subjects (Bernard, 1994; Wackerbarth, 1999; Stake, 2000). However, invisibility (anonyomity) is especially important for this group, who are known to value their privacy and are small in population size.

Following the snowballing or "secondary selection" (Morse, 1991) process, a list of 45 potential participant names and telephone numbers was created. As in any research with human subjects, individual participants had the privilege of choosing whether to enter the study or refuse. Interviews were obtained from this list according to the availability of participants and in keeping with the sampling criteria of qualitative research (Morse, 1991; Brink, 1991; Miller, 2000). Finally, a non-probabilistic sample consisting of 23 elderly EIIW from India living in the Edmonton metropolitan area were contacted for this study.

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[73] This is the first of the four life cycle stages of an East Indian person. This stage has multiple duties, including "studenthood." In the theory of hierarchy, a student occupies a subordinate/junior status. For detail see Chakravarthi, 1995.

Selection of Psychological Concepts for Semi-structured Interviews: It is very difficult for most immigrants to discuss mental distress because of cultural stigma (Chan & Indra, 1987; Vega & Rumbaut, 1991; Gelfand, 1995; Markides & Black, 1996) and racial/ethnic prejudices held against them (Kramer et al., 1991; Henderson, 1994; Meleis & Hattar-Pollara, 1995). Existing studies of elderly VMIs' mental distress focuses on ex-psychiatric patients (Markides et al., 1980; Pang, 1994; Noh & Avison, 1996; Schreiber et al., 1998) or clinical subjects (MacLean & Boner, 1983; Anderson et al., 1993; Singh & Kinsey, 1993; Mui, 1996; McCracken et al., 1997). Furthermore, cross-cultural researchers have studied limited topics in psychological distress such as depression, anxiety disorder or suicide. These studies mostly focus on one topic at a time and tell us very little about participants' understanding of the differences and similarities between these concepts. Importantly, the location of mental distress in the continuum of psychological problems is unknown for this group. To remove the participants' discomfort around this topic and to let them talk more openly about their understanding of mental distress, I chose six common psychological terms. Each participant was asked to share their understanding of: loneliness, grief, anxiety, worthlessness, depression and mental distress. Each participant was given the option to choose a word from this list to begin their interview. I found that eight participants had no preference in choice of words and none of the other 13 participants chose mental distress to begin their conversation. Finally, though every elder began their interview cautiously, within a short time they were sharing their personal stories with me.

C. Ethics

Approval from the Ethics Review Committee

Ethical dilemmas, questions and problems are central for both novice and experienced researchers who conduct research with human subjects (Andersen, 1993; Lofland & Lofland, 1995; Berg, 1998; Streubert & Carpenter, 1999; Stake, 2000). In qualitative research, issues of ethics and human values are especially sensitive in research on elderly subjects (Kayser-Jones & Koenig, 1994) or status-related research such as studying women (Reinharz, 1992), Third-World women (Mohanty, 1991) or race and ethnic populations (Stanfield II & Dennis, 1993). Today researchers commonly follow

the ethical codes set out by their associations/institutions to protect human subjects (Standfield II & Dennis, 1993; Lofland & Lofland, 1995; Soderberg et al., 1999) from any potential physical or mental harm (Wackerbarth, 1999). For this purpose, the data collection and processing procedures were designed following the University of Alberta Ethical Guidelines for Research involving Human Subjects (Appendix C) and submitted to the Department of Sociology Ethics Committee before actual fieldwork began.

After the ethics proposal was approved, in light of the patriarchic practice of East Indian culture (Davar, 1999) and sensitive nature of the topic, additional precautions were undertaken to ensure that the elderly EIIW participants would not experience physical or emotional harm. To avoid any potential harm to the research participants, three ethical issues were given special consideration: decisional capacity, anonymity and confidentiality, and informed consent.

Decisional Capacity: Decisional capacity means that an individual must have the ability or capacity to evaluate whether or not to participate in a research interview (Kayser-Jones & Koenig, 1994). This is especially critical for elderly EIIW who are seldom free from the family sphere, or as Gurumurthy (1998) explains, don't have the voice to make certain choices because of family honor and shame. Because of the high level of family involvement, the decisional capacity of elderly EIIW was assessed through a pre-interview invitation letter. This letter clearly stated the objective of the research, the type of people needed for the purpose, the nature and length of the interview, and the preservation of confidentiality. Before obtaining an interview appointment and informed consent, each prospective participant's decision to take part in this study was reassessed by re-emphasizing the research objective. Only when individuals agreed to participate in the study, they were given Dr. H. C. Northcott's (my supervisor) and my own addresses and telephone numbers.

To ensure the voluntary nature of the study, at the start of the interview all participants were assured that their involvement was voluntary. If they did not wish to answer any questions, they did not have to. As the interviews progressed, if an individual wanted to share any information with a tape recorder off, the message was not recorded or reported in the text.

Anonymity and Confidentiality: In the preliminary stage of this study, community leaders were assured by letter and in person about the maintenance of anonymity and confidentiality of research subjects. Nevertheless, at the start of every interview, I had to respond to queries from participants about confidentiality. In an attempt to gain trust and develop congenial relationships, confidentiality measures were explained to the participants before each interview. For example, all participants were assured that audiotapes did not show their personal names. To disguise their names and conceal their identities, case numbers were assigned on the audiotapes. All taped interviews were transcribed verbatim by the researcher, to maintain accuracy and protect participants' private information from outsiders. Moreover, audiotapes, transcripts, interview appointments (see Appendix D), consent forms (see Appendix E), interview guides and questionnaires (see Appendix F), and other written documents were stored in a secure location far from Edmonton.

Because they live in a community with a small East Indian aging population, and because of the nature of the recruitment process, some study participants knew their solicited friends. Therefore, to defend participants' privacy and eliminate any potential harm, at the beginning of each interview individuals were advised not to ask for information, in any form, about their friends. In addition to the above strategies, Reutter (1991) advises that, "Confidentiality and anonymity can also be facilitated by extending the time from data collection to publication" (p. 68). When time to publication is extended, participants may have moved away, gone traveling or died (Gupta, 1991). Nonetheless, to further protect participants' privacy a legend was prepared with fictitious names. Only these names are used throughout the dissertation. Finally, participants were informed that the dissertation and any resulting publications would be available to all and would contain no one's real name.

Informed Consent: A consent form (see Appendix E) was prepared for each potential participant. This formal written permission, known as "active consent" (Berg, 1998), has become especially critical in Alberta. In 1999, the Government of Alberta passed a by-law requiring active consent for any personal information involving human subjects. The key elements of informed consent are providing information about the research, ensuring comprehension of the information by potential participants (Standfield

II & Denis, 1993), and making sure that these individuals are knowingly participating in research of their own choice (Kayser-Jones & Koenig, 1994). Therefore, participants can terminate whenever they wish to, or refuse to answer any personal question (Soderberg et al., 1999) without adverse consequences (Kayser-Jones & Koenig, 1994).

In this study, informed consent was paramount because of the family structure and social situation of most participants. For example, one elderly woman refused to discuss one question for personal reasons. Another refused to allow her husband to read her transcribed interview, despite his desire to read what his wife said. I explained to the husband the University of Alberta's ethics committee's guidelines, which he accepted without further discussion. After this encounter, this couple was very supportive of my research project and found another five elderly women for the purpose.

II. Data Collection Strategies Utilized

Data collection began in September, 2000 and was completed in January, 2001. The methods of data collection were those conventionally associated with field research: face-to-face interviews and compilation of extensive field notes (Strauss & Corbin, 1990; Bernard, 1994; Berg, 1998; Streubert & Carpenter, 1999). Secondary documents were used for contextual and descriptive purposes, and limited direct observations were made during the interviews. Sanker and Gubrium (1994) suggest that "We can recognize grief, sadness, anger, and other strong emotions from the gestures and talk of strangers ... by paying attention to dress, body language, accent, mannerisms, and spatial mannerism" (1994, p. vii-viii). During the interview I attempted to capture and note some of these participant behaviors. Face-to-face in-depth interviewing was the primary data-gathering technique used.

A. In-Depth Personal Interviews

In-depth personal interviews are an effective method for collecting information about perceptions of participants or how participants come to attach meanings to certain events (Berg, 1998; Thomas, 2000). When the researcher is conducting cross-cultural interviews, the added objective is to invite participants to talk about their lives, perceptions, beliefs, experiences, interpretations or understandings (Kaufman, 1994b; Rubin & Rubin, 1995; Acharya, 1996). Therefore, to explore and understand the topical

arena, the researcher must allow participants some control. In this context, Prus (1994) makes this suggestion:

> Letting the participant "talk back" to the researcher is fundamental in achieving a more viable sense of intersubjectivity. Indeed, without this opportunity to uncover, ascertain, and qualify the meanings that others hold for objects in their life-worlds and the ways in which people go about accomplishing their activities in practice, it would make little sense to talk about studying human lived experience. (p. 22)

To achieve this goal and allow sufficient flexibility for discovering uncharted paths, this in-depth personal qualitative interview was structured in two stages.

Preparation of Interview Guide: The primary purpose of the interview guide or schedule is to help the researcher to explore and gain appropriate data without straying from the conceptual and substantive research topic. Therefore, the interview guide, also known as a "conversational guide" (Rubin & Rubin, 1995), contains broad yet central interview questions with probes and follow-up questions that have been predetermined and often pre-tested. One strength of a pre-determined questionnaire is that it generally "helps the researcher to have a clear idea of the research questions before embarking on the interview guide and interviewing itself" (Kaufman, 1994a, p. 124). Otherwise, poorly worded questions may generate invalid (wrong) or unreliable (inconsistent) answers. Therefore, these questionnaires clear the path for an interactive model of research (Sobo & Munck, 1998).

To enhance these person-centered interviews, a number of main questions were first prepared (see Appendix F) and pre-tested on two elderly EIIW. At this stage, my aim was to improve the data collection instrument and make it more reliable through clarification of questions. For validity and reliability, special attention was given to the wording of potential formal interview questions so that they would be easily understood and so that participants would respond to them without inhibition. The questionnaire was designed to collect both mental distress and demographic information. The first section of the questionnaire probed for general understanding of common psychological problems among the aged women: grief, loneliness, worthlessness, anxiety, depression, distress, and the coping process. The second section of interview questions gathered personal information. Each pretest interview was conducted in the participant's home, lasted 1.5 to

2 hours, and was tape recorded but not used as data for formal analysis. The revised questions were later made into a conversational guide for the formal qualitative interviews. While main questions covered the overall subject, the guide also allowed me to continuously explore underlying issues and to refine from time to time the predetermined questions as the formal interview progressed.

Formal In-depth Interviews: The formal in-depth interviews for data collection began with a preset list of broad questions. Although this questionnaire was used primarily to guide the participants and researcher through the interview, several probing questions encouraged the participants to remember and elaborate on their narratives, stories and examples for clarification, quotation and analysis (Wackberbarth, 1999). If any unexpected issue emerged, further follow-up and probing pursued the discovered theme. For example, early in the interviews several participants mentioned never feeling a sense of "worthlessness." This answer generated further interest in the reasons. Instead of dropping the concept from the question list, this word "worthlessness" was asked to all participants to explore why they don't feel worthless. Similarly, the first seven elders discussed how important it is to be able to drive a motor vehicle. Beginning with the eighth participant, every individual was asked "Do you drive?" and was encouraged to discuss the relationship between mobility and mental health. Occasionally participants were encouraged to use an Indian language to describe their understanding of a concept since "Choice of language is important for reflecting values" (Reutter, 1991, p. 61).

Initially interviews followed a defined format in order to increase the comparability of the cases (Stakes, 2000) and to learn about the similarities and differences in the meaning of mental distress. As the interviews progressed, new issues and questions emerged during discussion of the broad questions. Later, my role as a researcher was reduced to that of a moderator, and the original interview guide had limited use. Emerging themes were solidified and verified by participants.

Interviewing ended when the participants' explanations of mental distress (themes) were repeated in subsequent interviews and no new information was being revealed. This point is known as achieving "saturation" (Streubert & Carpenter, 1999, p. 22). The decision when to end data collection is related to the topic of sampling. Rather

than actually sampling a specific number of individuals, a qualitative researcher focuses on sampling the range of thematic content, that is, repetition and confirmation of previously collected data. A total of 21 participants were interviewed once in their homes, and the audiotaped interviews ranged in length from thirty minutes to 2.5 hours.

B. Observation

A field researcher cannot avoid observation during face-to-face interviews (Stake, 2000). Personal observation helps the researcher to verify a participant's response and to assess the effect of the researcher on the participant. As Chenitz and Swanson (1986) suggest, during data collection the researcher's presence needs to be continuously examined to minimize or control its effect on the situation being studied. One approach used to reduce the reactivity effect between the participants and myself involved revising the data collection strategy. For example, in order to feel comfortable about sharing their personal views, all participants wanted to learn about my permanent residence so I began to routinely disclose that information. It was equally important for them to understand that the objective of this research was not to evaluate or measure their mental health and I began to stress this routinely. These changes helped to minimize the feeling of uncertainty and discomfort among participants and increased their cooperativeness and openness. However, it is impossible to know how much information the participants withheld. Several times, interviews were punctuated by tears as participants recounted painful incidents such as loss of a husband or child, work failures, physical trauma, chronic illness, suicide attempts and family violence. In some cases, interviews were temporarily halted to allow the participants to compose themselves before they could continue.

Research bias (Bernard, 1994) is another philosophical issue that has drawn attention in field research. In this study, to minimize research bias and "threats to validity" (Sobo & Munck, 1998) attention was paid not only to the selection of interviewees but also to systematic observation of participants' activities, listening to words chosen during interviews and asking many questions in a range of contexts. Information was sensitively monitored and recorded in notes. However, notes were taken during interviews only after participating elders gave permission.

C. Field Notes

Field notes are critical to compiling effective personal accounts. They are a central component of qualitative research (Bernard, 1994; Berg, 1998; Clarke, 1999). Maykut and Morehouse (1994) describe the ideal qualities of field notes: "The qualitative researcher's field notes contain what has been seen and heard by the researcher, without interpretation" (p. 73). Bell (1994) likewise sees field notes as a source of description and also as a site of reflection. All forms of data logging -- interview notes, personal experiences, theoretical thoughts, methodological ideas and planning -- greatly assist in analytic work and theory construction, the hallmark of qualitative research in general and case study in particular.

Consistent with qualitative research exploration, field notes were maintained in the form of ideas, diary and questions relating to this research project. Lofland and Lofland (1995) call this first step in the field notes cataloguing system "mental notes." As individual interviews began, a comprehensive research journal was maintained under three categories: full field notes, jotting notes, and memo writing. The full field notebook included the recorded in-depth interviews with each participant. Observational information, interviews and diagrams were placed in a descriptive notebook of "jotted notes" (Bernard, 1994). An analytical notebook was maintained to record methodological ideas and arrangements. This notebook also contained memos (for example, conceptual or explanatory models) emerging from ongoing data analysis. All these notes helped in the clarification of interview data.

D. Secondary Documents

Secondary documents such as existing ethnographic studies, stories of personal experiences, life stories, anecdotal evidence, and diaries can provide significant contextual information (Bell, 1994; Denzin & Lincoln, 1994; Berg, 1998; Streubert & Carpenter, 1999). For this purpose literature on aged East Indian women and psychological problems was obtained through extensive library research. Many documentation resources (Bernard, 1994) are available to students of cross-cultural studies. From the exhaustive list of Congressional Information resources that are available in CD-ROM, in particular PSYCLIT, SOCIOFILE, MEDLINE, AGELINE,

CINAHL, CANSIM and CENSUS INDIA were searched. Other pertinent documents such as refereed articles, monographs, newspaper articles, news magazines (such as *Time*, *Macleans* and *The Economist*), on-line journals including the *British Medical Journal*, and local, national and international conference proceedings on immigrants and ethnic minority elders were collected. All cross-reference materials were indexed under headings such as mental distress, loneliness, depression, anxiety, grief, worthlessness, race/ethnicity, gender, immigration, the aged, classes, acculturation, culture, religion and coping practices. Medical records pertaining to specific elderly participants were not collected from any health care organizations (such as hospitals, physicians, or community mental health centers), as they were not the focus of this study.

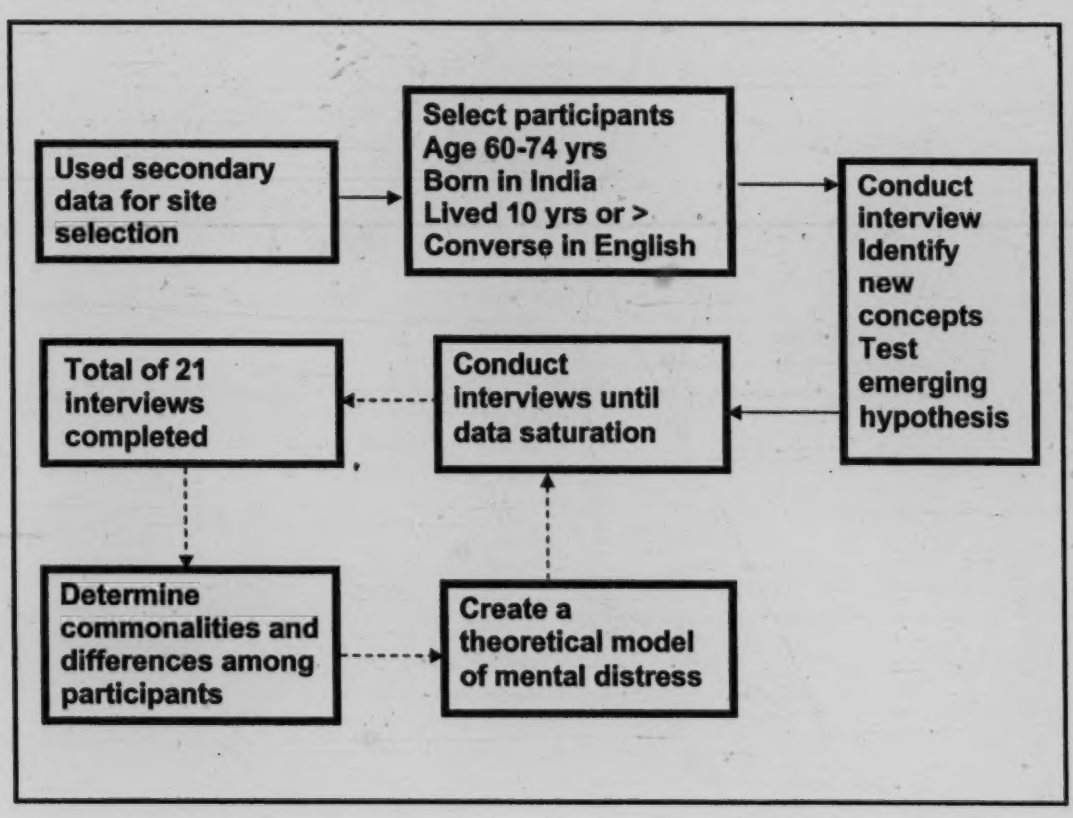
Used secondary data for site selection
Select participants
Age 60-74 yrs
Born in India
Lived 10 yrs or >
Converse in English
Conduct interview
Identify new concepts
Test emerging hypothesis
Conduct interviews until data saturation
Total of 21 interviews completed
Create a theoretical model of mental distress
Determine commonalities and differences among participants

Figure 3. Research Method.

III. Data Analysis Strategy

As there are different methods of data collection, there are also varied ways to do data analysis, the "nitty-gritty" of qualitative research (Corbin, 1986) and the "final stage of listening to hear the meaning of what is said" (Rubin & Rubin, 1995, p. 226). All collected data, whether quantitative or qualitative, must be organized, coded and analyzed. The difference, however, is that in quantitative approaches, coding and data analysis are conducted after data collection is completed. In contrast, in qualitative studies coding and analysis begin when data collection begins (Streubert & Carpenter, 1999). To develop explanations of mental distress from interview data, this case study followed three major procedures for data analysis: organization of the interview data, development of categories, and development of themes.

A. Organization of Interview Data

In all qualitative research where interviews have to be tape-recorded (Gubrium & Sankar, 1994; Gubrium & Holstein, 1994), the first step in analysis is transcription of the tape-recorded interview answers into a text file and thus the creation of a database. To establish a database, a number of computer programs, spreadsheets (for example, ANTHROPAC, ETHNOGRAPH, NUD*IST, ATLAS, SPSS, EXCEL and QUATTRO PRO), and word processors (including WordPerfect and Microsoft Word) are available to qualitative researchers (Tesch, 1991; Lee & Fielding, 1991; Ryan & Weisner, 1998; Babbie, & Benaquisto, 2002). For this study, the elderly EIIW's verbatim answers were transcribed at the end of each interview using Microsoft Word for Windows. This program is compatible with FOLIO VIEWS (Folio Views 4.11, 1997), a free-form hypertext database management program (Buchignani, 1996) for analysis.

During transcription, interview answers were subdivided into two parts. In the first part, demographic information was recorded using 13 descriptors: age, marital status, living in, living with, household composition, immigration date, immigration category, community origin, religion, language spoken at home, education, employment status and driving status. These descriptors were useful to illustrate the participants' diverse backgrounds (see Table 1). It is evident from this Table that the participants are not homogeneous in age, marital status, household, community, linguistic background,

religion, employment status, educational background or immigration period. These differences contribute to multiple positioning, which has implications for how to view and interpret issues, events or activities. Recognition of these differences has led feminists, gerontologists and other scholars to go beyond shared biology and oppression and to study both differences and similarities. In the context of mental distress, the goal is not only to find out the commonalities and differences among women, but also to examine the politics of age, gender and culture.

The second part of each word-processing file (e.g. Case#1.doc) included the in-depth interview answers to open-ended questions. These questions were based on six pre-determined psychological terms: loneliness, grief, worthlessness, anxiety, depression and distress. The respondents were not confined to a fixed set of predetermined answers. The textual data was separated by the above six terms (now referred to as "theme codes"). This preliminary separation of each theme had two advantages. First, it allowed me to make crude comparisons of the most frequently used words to explain these terms. For example, participants extensively used the English expression "loneliness" or "lonely" to describe the meaning of depression and its link with distress. Second, this preliminary organization of interview data guided me in the subsequent "theoretical construction" (Tesch, 1991; Lee & Fielding, 1991) analysis using the Folio Views database. All transcribed interview files were collapsed into one Master Import File named "Verbatim 2.doc" for identifying and retrieving themes, phrases and words.

Identification of Categories and Themes

This software generated a complete new Infobase file named "nina4.info" in which every word was automatically indexed. Folio Views "knows" (Buchignani, 1996) beyond the presence of a word in the infobase text (Bernard, 1994). It recognizes where each word is located in the voluminous textual data. Moreover, the program uses every carriage return to mark a paragraph (called a "record"). In total there were 5,208 records in this transcribed non-numerical interview text. This computer program not only enhanced the building of "filework" (Denzin & Lincoln, 1994) or "organization" (Clarke, 2000), "diagramming" (Corbin, 1986), and "indexing" (Buchignani, 1996; Miliken, 1998) of personal notes and research text; it also helped to analyze the data from an emic

perspective or, as Miles and Huberman (1994) term it, without "going native."

"Without going native" means reading through transcribed text and marking the main themes, phrases or concepts as they were expressed by the participants. For example, in an attempt to identify the subjective meaning of loneliness, grief, worthlessness, anxiety, depression and distress, combinations of words, themes and characters were used. The construction of theme is illustrated in the quotations below.

> I think all these words [loneliness, grief, worthlessness, anxiety, depression and distress] are connected. They mean *worries*.
>
> The words are all the same, almost the same meaning (worthlessness, depression, anxiety, distress and loneliness). [For example], because of the worthlessness a person falls into depression and then he starts his feelings of anxiety, and the rest.
>
> They are mostly inter-related and mostly the common pattern.
>
> You would perhaps notice that it is not used by anyone in my generation [EIIW], the words depression, worry, distress, anxiety and so on. All these are *negative emotions*, waste of energy, waste or diverting productive energy to useless things that have not accomplished anything.

To explore the connections between categories and the process of knowledge construction, some of Glaser's (1978) 18 different predetermined theoretical codes were used. In particular, for the analyses of data the six C's were applied, the "bread and butter" (Reutter, 1991, p. 63) of analysis: causes, contexts, covariances, contingencies, consequences and conditions. "Types" or "dimensions," "temporal order," and "strategy," were the other predetermined subcategories used in questioning and analyzing the data. For example, in this study, the following questions were asked:

- Is mental distress different from other emotional problems?
- Can this problem be divided by sequential order, that is, does one emotional problem lead to another in a predictable sequence?
- Under what circumstances does mental distress occur?
- What is its consequence?
- How is it managed?

The questions about the conditions and context that produce mental distress generated categories such as "loneliness," "unprepared events," and "mistreatment by children." These eventually were clustered under "cultural difficulties." Through this procedure five other categories were identified as potential causes and consequences of mental distress. The first two are causal categories: "personal issues" and "health related issues." The last three categories examine the consequences of distress on "physical," "social," and "mental" health.

By staying close to the existing categories and paying attention to prevention and coping strategies as indicated by participants, maximizing a "sense of control over the participant's internal self" emerged as a core category. Therefore, in order to explore the mental distress management process of the elderly EIIW, new themes were developed by connecting issues and personal activities mentioned by the individuals. This process shows how elderly participants used their personal and cultural values, morals, beliefs and attitudes to manage their life crises and to prevent or curtail the risk of mental distress in their later years. In short, for achieving optimum wellness, these women strongly believed in and integrated various personal, cultural and spiritual "ideologies" as their everyday resources. Their actions were related to five major East Indian cultural beliefs, which can be viewed as "traditional" (or Indian) ways of defending against actual mental distress. To "maximize a sense of control over the inner self" and to avoid "permanent invalidity" in old age, the participants are occupied in: 1) redefining the meaning of family or householder (grhasta); 2) religion and spiritual activities (dharma); 3) reflection on the past events and acceptance of their fate and action (karma); 4) evaluating their material well-being or "financial security" (artha) in preparation for living independently; and 5) idealizing independent living (sannyasin), a symbol of Canadianization. Although these concepts are interrelated, the first four are vital for managing everyday emotional and psychological problems. They give these women a sense of self-worth, regardless of their social, race/ethnic, sex, educational, linguistic, rural/urban origins and financial status. Even if all elders do not experience the same mental strains, for every elderly EIIW self-worth (or self-esteem) acts as a shield against mental distress. Also the discussion will highlight how for many elderly EIIW culture occupies the status of "moral medicine" in a crisis of mental distress.

IV. Characteristics of the Research Participants

The twenty-one English-speaking elderly EIIW who participated in this research came from diverse backgrounds. They varied in age, marital status, living arrangements, year of immigration to Canada, immigration category, community of origin, religion, language spoken at home, level of education, employment status and driving status (see Table 1). Eleven women (52.4%) belonged to the age range of 60-64 and 10 were 65-74 years of age. At the time of data collection a large percentage of women (76.2%) were married and lived with their spouse in a two person household (61.9%). Of the 21 participants, 12 (57.1%) identified themselves as Hindus, six (28.6%) as Christians, two (9.5%) as Muslims, and one (4.8%) as a Sikh. The majority (61.9%) of the women had immigrated between 1960 and 1969. Ten (47.6%) came under the assisted relative category, six (28.6%) under the family reunification class, and five (23.8%) under independent criteria. The majority of women interviewed had some type of post-secondary education. About 81% reported that they came from cities in India, and at the time of interview 90.5% were not working for pay. When participants were asked to specify if they drove a motor vehicle, 12 (57.1%) said "no" and nine (42.9%) said "yes." Finally, there was diversity among the 21 participants in terms of the language spoken at home and the state (i.e. province) in India they identified as their place of origin (see Figure 4).

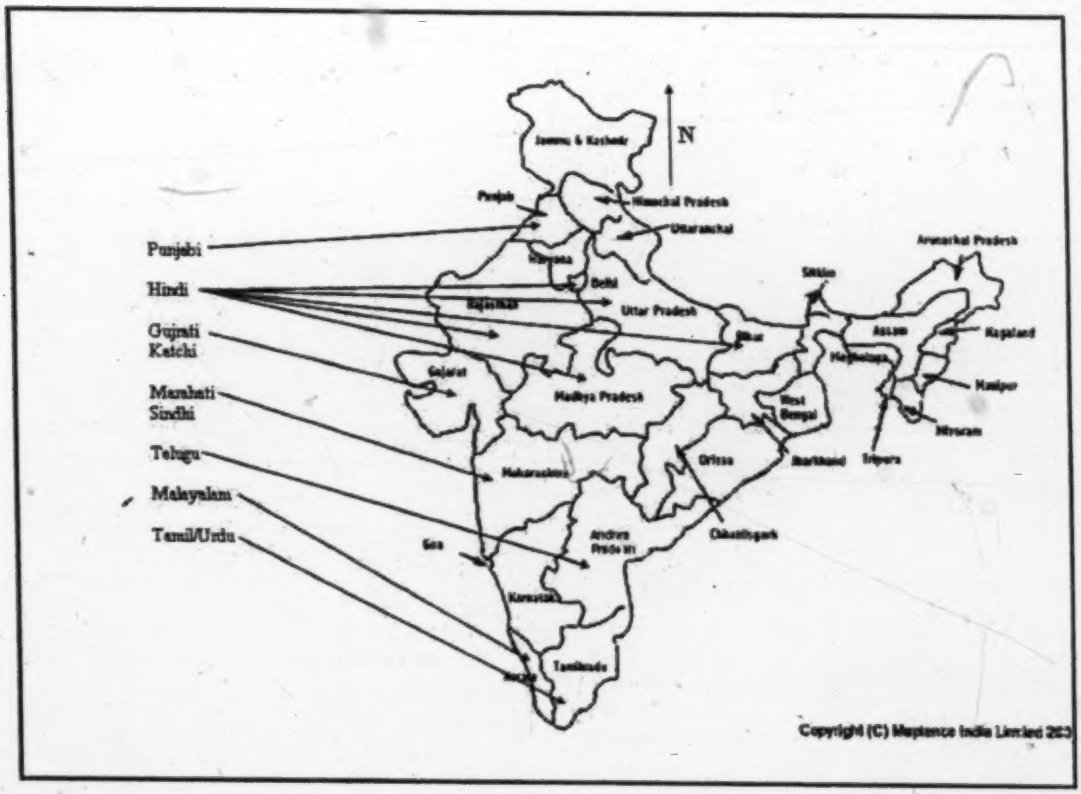

Figure 4. Map of India showing EIIW participants place of origin and languages spoken in the area.

Table 1. Sample Demographic Characteristics (n = 21), Alberta, Canada, 2001.

Characteristics	N	%	Characteristics	N	%
Age			**Religion**		
60-64 years	11	52.4	Hindu	12	57.1
65-69 years	5	23.8	Islam	2	9.5
70-74 years	5	23.8	Christian	6	28.6
			Sikh	1	4.8
Marital Status			**Community of Origin**		
Married and Living with:			City	7	81.0
Spouse	16	76.2	Town	3	14.2
Widowed	3	14.2	Village	1	4.8
Divorced	1	4.8			
Separated	1	4.8			
Household Composition			**Language Spoken at Home**		
Living Complex:			Hindi	4	19.1
Detached House	17	81.0	Malayalam	6	28.6
Semi-Detached House	1	4.8	Marhati	4	19.1
Apartment	3	14.2	Telugu	1	4.8
Living Arrangements:			Urdu	1	4.8
Living with: Spouse	12	57.4	Punjabi	1	4.8
Son	2	9.5	Kachi	1	4.8
Daughter	3	14.2	Sindhi	1	4.8
Grandchildren	1	4.8	Gujrati	1	4.8
Other	1	4.8	English	1	4.8
Alone	2	9.5	**Driving**		
Number of People in Household:			Yes	9	42.9
			No	12	57.1
Single-person Household	2	9.5			
Two-person Households	13	61.9	**Currently Working for Pay?**		
Three-person Households	4	19.1	Yes	2	9.5
Five-person Households	2	9.5	No	19	90.5
Immigration to Canada			**Education**		
Between the Years:			Elementary	1	4.8
1960-1969	13	61.9	Junior High School	3	14.2
1970-1979	4	19.1	Some Secondary School	1	4.8
1980-1989	2	9.5	Secondary School	1	4.8
1990-1999	2	9.5	Some Community College	3	14.2
Immigration Category:			Community College	3	14.2
Independent Class	5	23.8	University	4	19.1
Assisted Relative	10	47.6	Post-Graduate	5	23.8
Family Reunification	6	28.6			

CHAPTER FIVE

INTERPRETING AND EXPLAINING MENTAL DISTRESS: THROUGH THE PERSONAL LENSES OF EAST INDIAN ELDERLY IMMIGRANT WOMEN IN CANADA

This chapter explores the meaning of mental distress and its symptoms as interpreted and explained by elderly EIIW. A definition of mental distress emerged from the narratives the participants gave in interviews and informal conversation. Their explanations of mental distress inevitably touch on questions of meaning, causes and consequences. In addition, these women pointed out mental distress issues that are specific to the EII community. The findings of this study illuminate how past, present and uncertain future events influence the construction of the mental distress. In short, EIIW elders' explanations of mental distress help to reveal the role perceptions, beliefs, ideologies, attitudes, experiences, and rational and non-rational imagery (Hazan, 1994) that have shaped their actions in everyday living.

I. Perceived Meaning of Mental Distress

Most earlier scientific literature has described mental distress within the western medical context as "mood disorder," "silent illness," and "psychological disease" (Kahn, 1998). In this study, the participants described mental distress and other common emotional problems as "negative energies." The participants believed that mental distress means loss of control over one's humor (heart), mind (brain), and body (the whole person) (see Figure 5) (Weiss et al., 1986; Krause, 1989; Pert, 1997). They believed that negative feelings come from life's every day challenges and from a weak inner self. Although the participants had no serious personal problems, they perceived that challenges are inevitable for physical, personal and social reasons. In this study, the participants' perceived meaning of mental distress included "unhappiness and disappointment in life," "inability to cope with demands in one's life," and "the stress for which there is no cure." Like many elderly, these participants also indicated that mental distress is a generational and cultural issue. Furthermore, the elder's "impressionistic views" (Blakemore & Boneham, 1994) influence the construction of mental distress as a problem of the "other" (Douglas, 1995). Indeed, participants were reluctant to discuss mental distress as a

problem that they themselves experienced.

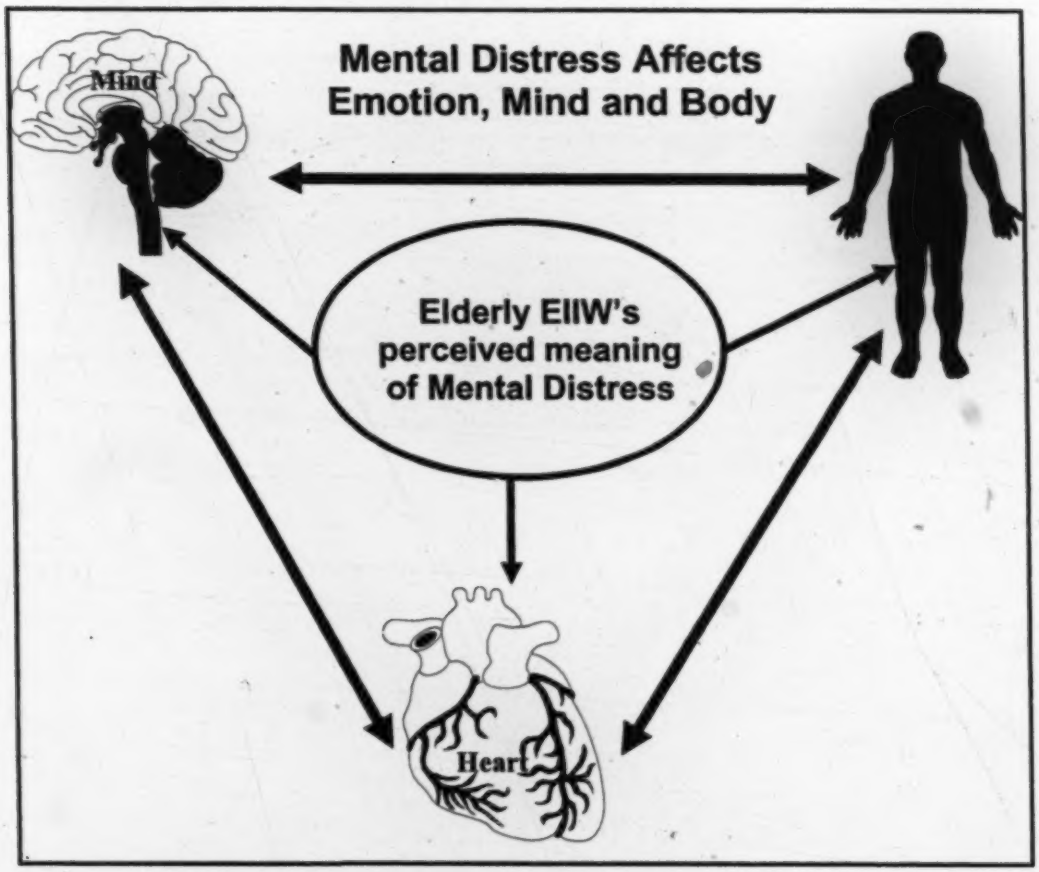

Figure 5. A Pictorial Description of Mental Distress by Elderly EIIW.

"Distress Means Unhappiness and Disappointment that Comes in Life": Emotion

In this study, all participants talked about the challenges they faced when they immigrated to Canada. Their definition of mental distress was based primarily on their personal experience, beliefs, and attitude towards life. Initially, however, they began their conversation with statements such as "I never felt," "Not my problem," or "Most of these things don't affect me." This is succinctly captured in Neeta's interview introduction:

> Let me make it very clear, I have not experienced any of those things. I am [a] self-sufficient individual. Normally, [however], none of these words, feelings that are expressed by these words that you have selected are never verbalized by anybody [i.e. EIIW] of my generation. They may feel it, [but] they won't say it.

Despite the personal disavowals, the elders defined mental distress (as experienced by others) as a feeling of unhappiness. Some mentioned that unhappiness could arise from external problems. However, most linked unhappiness with personal troubles. According to Kunita:

> Distress means something bothering you. Too many times when you are working hard and money [is] not coming. Not my problem. Some people have money problems. Sometimes husbands seeing other women. So many problems! Sardar [meaning Sikh] men do. Sometime they do, very rare. May be one percent, may be fifteen percent (a laugh). I don't know!

Mita described distress as a feeling of sadness and worries:

> [Dis] stress comes from sadness. If you are not sad then you don't have [dis]stress. If you are worried of something, just like I told you I am worried about my daughters, like that. When you said your mommy and daddy are happy, then you don't get [dis]stress.

In addition, many of these women perceive mental distress as temporal (Kakar, 1982; Shirali, 1998) and context-specific (Chakroborty, 1990; Sandhya, 1994; Davar, 1999). This perception is reflected in Sumita's response to the question "What does the term 'mental distress' mean to you?"

> I haven't thought about it. Distress, it means "upset." I guess I will associate it with upset. I am distressed because something happened. It's not a permanent thing, but a temporary thing. I would say distress is getting upset about things and getting angry.

While most participants (regardless of whether they immigrated from urban or

rural centres in India) focused on a context-specific definition of mental distress, a few explained the meaning from their personal experience. Sabita, for instance, described her own experience of distress:

> Not happy. They don't feel good. That is distress, I think. That [is] what I think. Yaa! Don't you think? I don't know how old you are? When women get menopause it does like that. You feel sad, sad. However happy you are, your children, your husband good. How much money you have? That period makes you worst. I know that. Sometimes you go angry, so angry. Angry, you don't know. I am shouting, shouting. Your temper is high, high. This happened to me two, three years like that. My husband say [said] "Why are you doing like that? Don't do like that." But, however they say nice, you feel you're... Then you realize what you are doing. Then you cry and when you cry you feel better.

Sabita used words such as "sad", "crying," "angry" and "shouting" to describe her unhappiness while going through menopause. Though menopause is a natural event in the lifecycle of women (Granville, 2000), it causes distress in many (Kahn, 1998; Bonita, 1998).

Punita took the point about changes in lifecourse further. She indicated that, in Edmonton, "lack of culturally sensitive health services" has increased unhappiness among many elderly EIIW and men. This participant thinks that the fear of uncertainty in later years is a major source of unhappiness among EIIW elders living in Canada:

> [These women might be thinking] what happens to me at the end? Which kind of ending are they also thinking there? And where the [Canadian] government can intervene? I think so [many of our women are suffering]. Many people are now beginning to feel, before they get old also, "What will happen to us?" [Therefore, it is important to see] how to make them feel happy. Cheer them up, talk to them and give them support. Support in a sense to encourage them to feel they are worth something.

Despite awareness of the association between life course changes and mental distress, most elders still viewed this as a normal part of life. In the words of Jeeta:

> Distress comes in daily life and we live with that, that's all. I can't tell you [what type] exactly. As it comes you deal with the things and you go ahead with the things. That is nice. Sometimes you want to do things and you can't. You have some difficulties to do that or, you know, some obstructions to do that. [Say] "Oh me, I fantasize I want to go somewhere or do something, or call somebody or give something." See, most of the things you are asking don't affect me. That's the thing.

The nature of their experience of distress was another topic that these women discussed in their interviews. Most indicated that distress is temporary or provisional. It affects only the inexperienced (the young) and the weak. Wehry (1995), Heidrich and Ryff (1996), Allen and Phillips (1997), and Gutmann (1997) found similar results in their earlier studies. They explained such perceptions as one of the strategies for coping with the social stigma attached to mental distress and old age.

"Distress Means the Inability to Cope with the Demands in One's Life": Mind

The second definition of mental distress relates to the issue of inability to cope when one encounters everyday demands in life. Here, the participants discussed how women tend to experience psychological difficulties and mental exhaustion when they perform multiple activities or duties. Lalita expressed this view when explaining her understanding of mental distress:

> For me distress means something like "tired of something." You see, I think it is. I have never heard anybody saying like that, "experiencing distress." I never heard [the word] "distress." [So] distress means overwork and sometimes expecting things from children and husband. I never felt. I am always happy to do things [a laugh] as much I can.

For Babita, the meaning of distress came to symbolize her past experiences, at times stressful, related to raising a young family in Canada. Today, only one concern, her grandsons' future, keeps her mind occupied with worries:

> What is distress? Tell me. [Is it] not disturbed? [I think] if you "cannot handle it," it is a stress. Time frame is a stress. I don't have any stress with the kids. But when they were young I had stress. [For example,] their marriage and what their future, you know. Now both of them are in good position, you know. Not really, financially we don't have any stress. We don't have stress from our kids. But the younger kids [grandsons], I always think about [them]. What the future is for the boys. They are so naughty [and] then I am thinking "What will be the future?" [a big laugh] Actually, I am worrying about the younger one.

The women's descriptions of the meaning of mental distress reflect the multidimensional nature of the problem. Their narratives support multiple role theory (Norman, 1985; Tausig et al., 1999; Cockerham, 2000) and the influence of a person's social roles on the personal construction of the meaning of mental distress. In addition, some indicated that not everyone has the same level of mental ability to handle the

physical and social demands of life. Others saw distress as a problem of attitude. Jeeta explained:

> [Dis] stress is that something more than you can handle things, you know. Like people say, "I am stressed out because I have so much to [do]. I have to go for work and I have to look after my house.

Neeta, a grandmother, further explained the diversity in the experience of distress:

> I never use the word [distress] [a big laugh]. Oh, I guess possibly [the] "inability to cope" with all the demands in their lives. Whatever! If an individual can be stressed out if they, for example, have to cook for five people that might be a stressful situation for that individual. Taking the car out on icy road can be stressful. So there is absolutely no reason for being stressed out. Somebody may just make a habit of feeling stressed because they are grown used to that. As many times as you hear the word "stress," it's a different scenario, every case is different. And you can think, "What is wrong with these people, what is there to be stressed out?" And that depends again upon you, how you react to other people's stress. Not everybody is stressed out all the time. But some people may feel the stress at the merest deviation from their normal life. Whatever it is, it doesn't matter. If I have to miss my breakfast because I have to catch a bus, [that] could cause stress to somebody. Slightest thing! Or if a baby begins to cry they get stressed out. So it depends on an individual. That's my understanding.

It is clear from the interview data that using words such as "inability to cope," "unable to handle it," or "tired of something" permit these elders to reject mental distress as illness or as purely a medical matter (Fernando, 1995; Butler et al., 1998). Instead, distress is viewed as an extreme form of social stress that is attached to general life satisfaction and lifestyle. Therefore, an individual's internal locus-of-control, "the internal self" (Pert, 1997), is central to dealing with social pressure. Many participants believed that distress is an attitude and is primarily a "generational" issue – a claim much in accord with selective perception hypothesis (Barrow, 1996). This construction of difference based on generation, knowledge, time, and social, cultural and geographical space is further elaborated in the final definition of mental distress.

"Distress is the Stress for Which There is no Cure": Body

As the elders began to think more deeply about the concept, they redefined mental distress as a stress for which there is no cure, one which may affect the individual's physical self. In this context, several participants focused primarily on the issue of the

incurability of distress, leading to death of individuals. Kabita explained:

> Distress means trouble? I am asking you. Stressed out [means] tired, exhausted. Stressed out means so much pressure on you; pressure of profession mainly here [in Canada]. Just last week there was a doctor, he was so great, so good. After stepper he started to dance, because he was invited. And right there he passed away. It's so sad, you know. His wife went to India... she is such a nice person. He was also nice. Because of stress, you know, stress of profession too much. Doctors are having hard time, because of lot of hard work. Day and night they have to be on duty. In that respect, I am not stressed out, neither is my husband. Stress is always there, and competition brings stress on you that you have to be. For the Indian people, they have to be proved double better people than the regular local people from here. That brings stress on us. Because we have to prove. Our people are very forward in these fields -- technology, medicine or law -- and that brings stress on us. To go higher or to prove to be a better person [they work hard]. Now I am at home, I don't have stress. When you go out and work or go into the public, or hold a public office, then you have a lot of stress.

This elder's view that death from distress occurs among people who are in a profession underscores the belief that work demands can bring death, something that EIIW elders don't experience. They don't have the pressure that their male counterparts face in the public sphere. Kabita articulated how ethnic/racial categories can negatively affect mental well-being, as she had experienced during her professional career:

> [Our seniors don't have distress], no, I don't think they are going through stress. In that way they are okay. Stress is something through which you guys are going. Because you are having profession, working. You have to compete with other Canadian people to come forward, to be better than them. Otherwise you don't get the chance of having a job even. They will snatch your job even. That's what happened to me. My job was gone because of that. I lost my job. I was [a] school teacher here. I was teaching in Mundare. Vegreville was close to Mundare. I was teaching I think 15 to 20 years. I taught here and then they harassed me so much that only they didn't shoot me. They harassed me so much. So I gave up the job and I started working with my husband.

The association of discrimination, mental distress and death was further elaborated by Sunita. This participant strongly believes that she lost her 40-year-old son because of systemic discrimination and harassment from the city administration and the school board. Sunita explained:

> We went through stress. All those with government things and even parents and children, they were with us. But they couldn't stay any longer, because it was too much stress. That's the way we spend our days, losing things, all of us, which you have made [yourself]; so much material with [your own] hand sitting at night; making those materials for children. What I have to give, all those things and they all got destroyed. So what god created so much [many] things, whatever city want to do, they will do it. They won't listen. They have their own agenda. Stress was so much that my son died from it and my daughter was losing speech.

While these women reported that distress means death or disability, Amita summarized the meaning of distress as follows: "I think to me distress is the stress for which you feel you have no cure." Finally, Geeta explained mental distress as something that one feels when waiting for death, or fear of death with old age:

> No, I don't feel distress, no. That's what I will feel if I have to lie in hospital bed one day waiting for the final moment to come. It may and I am working very hard for that moment in my life when I should not feel distressed. I should feel that my life has come to an end and I should be willing and graciously…where I feel totally fulfilled and ready to depart [and] not distressed to depart, I think that's my final acid test for myself. The "death," the ultimate departing from this world will come. I should be ready to embrace it very happily, very contentedly if I have done my duty in this life. I think that is the purpose why god sent me here.

The western system of biomedicine describes mental distress in terms of sub-clinical problems that primarily affect the mind and body. However, in this study the participants viewed mental distress as a normal event in the life course. It is temporary, context specific, and an individual problem. The following section reveals the perceived causes of mental distress among elderly EIIW living in Canada.

II. Perceived Causes of Mental Distress

To the participants, context-specific problems meant extrinsic (or environmental) factors and intrinsic (or biological) factors or both. Therefore, when asked to explain the probable causes of distress for elderly EIIW within the Canadian society, they mentioned common problems including cultural difficulties, personal issues and health-related issues (see Figure 6).

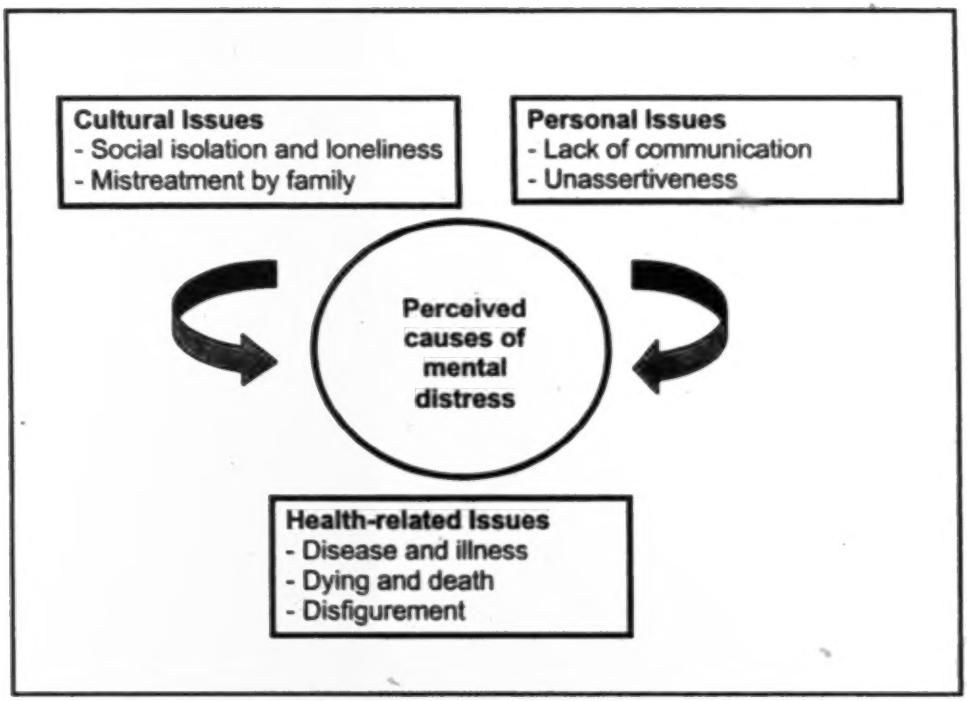

Figure 6. Model of Perceived Causes of Mental Distress of Aging EIIW.

It is important to reiterate that this diverse group, individually and collectively, consider mental distress a concept associated with western civilization and with the modern way of life. The key characteristics of western civilization are urbanization, technologization, a materialistic lifestyle, nuclear family structure, welfare state, increased mobility (both geographical and social), low fertility, low mortality and increased life expectancy (Isajiw, 1999; Macionis & Gerber, 2002). This perceived connection between mental distress and western civilization is corroborated in one participant's comment: "Distress? We hear this word quite a bit in Canada."

These non-European aged immigrant participants feel that because many EIIW elders have opted to spend their later years in Canada, a country whose mainstream culture is essentially modernized (Baker, 1993) if not post-modernized (Isajiw, 1999), they face a greater risk than their Canadian-born counterparts of experiencing mental distress. Most important, they believe that mental distress is a significant threat to older immigrant women who are handicapped by their traditional Indian ways of thinking, who

prefer a traditional lifestyle in old age, and who are experiencing losses in every aspect of late life in a new country. The risk may become even more severe for people with language barriers and for those who have immigrated at a later age, particularly in the family class category.

A. Cultural Difficulties and Mental Distress: The Social Reality

Despite their differences in immigration history, age, marital status, religion, community of origin, language and educational level, cultural difficulties formed one of the most prominent themes that emerged as a cause of mental distress among the EIIW elderly population. In discussions of cultural difficulties, the elders identified loneliness, mistreatment by children, and unexpected events in the family/household as core stressors causing mental distress among this aging population.

"For EIIW elders, distress comes from loneliness." Loneliness, for Butler et al. (1998), means the fear of emotional isolation, of being locked inside oneself and unable to obtain the warmth and comfort that can be gained from others. However, to these elderly participants loneliness meant not only emotional isolation but also social isolation, such as lack of companionship, limited mobility, and lack of attention from family members. Therefore, there is a general consensus among participants that mental distress is highly correlated with loneliness that comes from a sense of isolation. Wanita explained:

> You know all the problem[s] comes from death [and] loneliness. Because for our people all distress coming from the loneliness or say no company here or no company there. Just like, if kids have moved out of the house [and] husband is busy in the business, you staying and if he goes outside you can't go outside and you say, I am depressed. There, in India, you can go any house anytime. Here, you have to phone them, "OK! I am coming." Then they will say, "Oh, I am busy and you can't make it today." That is what people say here. In India, I have told my friends, "Come anytime you come. The door is open twenty-four hours." People come and go. But nowadays people want [you] to phone them, ask time or tell them [that] I am coming, invite them for supper. Then they come. Before, they don't come. [They would say] "I have no time." If you don't have time, say some people make dishes as a group for function. They will say, "Oh, I can't make it. I can't come," because they don't want to cook (a laugh). If you call them they will be free. It is a two-way road. That is why [Indian] people cut off from each other. Everybody is saying, "I am

> old, I am old. I can't cook, I can't cook." If you are old, you can cook at home for your family. How come once [in] a while you can't make dish? "No, I am too old and now I am retired." I feel like those people are not good. No use to keep in touch with them. If you want to feel the relationship then you have to do both ways, not one way.

This problem, Sabita believes, is even more severe for non-English-speaking and elderly EIIW widows:

> I got a friend she always say, "Oh, I don't have anybody." She is all right with her son. But his wife is not looking after her. I have seen in my own eyes. She is living all alone, because [her] son's wife don't like her. And she don't understand at all. Nothing. Oh! Absolutely she don't speak nothing, no. Her son's wife, she don't like that old lady in the house at all. She said, "Where should I go, where I can go?" And she don't have any daughter. So, she is crying, crying. Because she [is a widow] don't have husband. So that is why she stay[ed] here. Her son called her here. But his wife doesn't like. What can I do? I don't want they both stay separate. I will separate. Let them enjoy their life.

Kunita shared her personal experience of loneliness and distress while living in a joint household in Canada:

> When your husband is with [his] mother and give attention more to mother than me, then you get loneliness. Your children are out, one in Calgary and one in Kentucky. You don't have a daughter to speak to; you don't have mother to speak to; you don't have anybody to speak to. You can't talk with sister-in-law because, she takes advantage of you. Understand? You have no daughter to speak to, no husband to talk to, then you feel lonely and [dis] stress. You see, daughter is very important in [your] life. Some people have daughters, they go and visit them. Then the daughter come home, spend time with them.

Bonita, describing the Canadian cultural environment, explains loneliness in terms of missing the closeness, interdependency and supportive communal living of traditional Indian culture:

> In Canada there is too much loneliness. Too much! Because it is a different culture. There are neighbours, but not like India. I have neighbours, [but] I don't know them. In India, whoever is your neighbour you know them very, very well. Though it is happening in India; people are going away, living far away. It's changing, India is also changing, but not like here. You see at least [if] there is nobody [family members] at home, there is a servant who will come and clean. I can talk to her. I can sit on the balcony and see some people playing in my language. So you don't feel lonely. You feel lonely, but not as lonely as [you] are feeling

> here because we have our own culture. When we are switching on TV, it is our language, which I can understand my culture. Here I can, who stay here after fifteen years, I can understand. But as I enjoy my culture, I don't enjoy.

Sunita revealed that she occasionally experienced loneliness and sadness at not attending social events in India:

> In my opinion, probably the only time personally I felt lonely, for example, there is a wedding [in India] I am not able to go. Then I feel like, "Oh no, I wish I could have been there." You feel lost or lonely in that respect in my opinion, in my case.

Wanita also described mental distress in terms of feelings of loneliness, displacement and sadness:

> Loneliness is when you miss the family when you can't talk to them. You are lonely, when you can't afford to go to India all the time. So, you miss them so much and you feel lonely that you think, "For what we came here, for fun?" Nothing, because it is like who come here they have half life here, one leg here; one feet here and one feet there because they don't [live] close to India, because family is there and we have to go there for children once in a while. If you don't go, you feel lonely and sad. Somebody died in the family [and] you can't go, because of the situation. You can't afford the money and gift and something like that. Anything happens we can't go. They feel bad, you know, because last time it happened I didn't go. And you feel guilty too and lonely because you couldn't see [them].

Anita described another example:

> Very recently, one of my friends lost her friend in India [and] she was grieved. When they left their country they lost their friends in India. They cannot go and take part in sad event or, you know, in happy events, like young people's party events. They are left alone.

These participants recalled feeling guilty for not attending death and funeral rites of family members, close relatives or friends, an important structural part of Indian family life (Devadoss, 1979; Chakraborty, 1990; Sinha, 1994; Lamb, 2000). Rita confirms the association between living alone in Canada and mental well-being:

> At this point, nobody is living with me and I feel so alone. And for [a] long time I have been depressed.

Geeta, a part-time health care worker, combined several social network factors to suggest that lack of friends, joint family household, religious and cultural institutions may

influence loneliness, which then contributes significantly towards distress:

> Loneliness means you have nothing to socialize with people. And you have nobody to socialize to, nowhere to go, no one to talk to or no one to express your feelings, your inner feelings. That's what I think. Sometimes you have some feelings that you don't want to talk to everybody. You may have feelings build up inside that you want to talk to somebody. But you don't have anybody. That means you have no friends, or you have no families, close families [and] no employment. And you don't have your church group or those kinds of [things], you know, your own language church or your temple, or whatever you have is not here and you become very lonely, I think. Then it brings distress.

One other major explanation for the developmental etiology of distress among EIIW elders is the loneliness that comes from living in a nursing home in old age, especially when there is a clash of culture of the aged in an institution (Wade, 1993; Bassi, 1995; Levin et al., 1998). Neeta pointed out that the culture of Canadian nursing homes is a main concern of this group. She used herself as an example to make her point:

> [Many of our women] are going to end up in nursing homes. And our nursing homes here [in Canada] where they try to help everybody, they cannot help our seniors. Language becomes an important thing. And the young people, who do not have time for the seniors [or elders] when they are at home, would have much less time when they are in nursing homes. And that's where your loneliness begins. So we have two, three generations grown up here. Even take people like me. I am not saying it will happen to me. But think of a time when I might have to go into a nursing home or something. What common interest do I share with the rest of the residents in a nursing home? What activities there can I participate in? I don't play Bingo! I don't do cha, cha, cha or whatever. What else do I have? Our generation, the first generation immigrants are getting to a stage where the next step is a nursing home. What services do we have for us? Certainly, they will experience loneliness, depression and distress.

These elderly participants' personal views about the potential structural environmental forces of loneliness and mental distress illustrate the cultural dimension of this group. They are a community that values companionship, family, relatives, friends, community centres, and religious institutions (Pillai, 1985; Gangrade, 1988; Upadhyay, 1994; Sokolovsky, 1997; Gurumurthy, 1998; Butler et al., 1998). They see children, language and aging at home as their main assets in preventing mental distress (Chakraborty, 1990; Mahajan, 1992; Sandhya, 1994; Negi, 1996; Dandekar, 1996). Earlier South Asian Canadian gerontological community studies indicated that South

Asians do not experience mental distress because they have a strong community network (Bagley, 1992; Guzder, 1992; Bassi, 1995; Raport Report, 1996). However, the participants in this study indicated that lack of social and personal resources place women at risk of mental distress. Others expressed concerns about the future. This point is reflected in Vinita's account:

> Loneliness is nothing to look forward to, nothing to do, and you are sitting alone, you know, and you get depressed. That is when it is good to be with a group or work with a group or something. You see, in my group I don't know [if anybody is feeling lonely], because everybody is doing one or the other things (a laugh)... I can't see so far, because everybody has husband and wife, children you know. Maybe in future something will happen or one will go or, you know, then I don't know. Now everybody is so busy with everything, even they have no time to sit [and] worry. Because their grandchildren they are looking after (another laugh). Now you don't know. Afterwards you know how things will go for yourself or myself [me] or anybody.

"Some [East] Indian people [adults] are very cruel. They suffocate their elders." While a few expressed idealistic views such as changing attitudes will reduce loneliness and mental distress, most expressed the impression that among EIIW aged, loneliness and mental distress are enhanced over time by their children's mistreatment. In fact, all discussed their concerns about mistreatment of EI elders, particularly immigrant women who have come to Canada primarily under the family class category and live in a joint family household (also known as multigenerational living conditions). These participants explained how the intrafamilial relationships of elderly EIIW living in Canada are linked to the progress of loneliness and mental distress.

In the narratives about children's mistreatment and the development of loneliness and impairment in mental health, the most frequently mentioned intrafamilial issues were restrictions placed on elders' social life, changes in the relationship between elderly parents and married children, and limited mobility. Anita substantiated these three points:

> Well, [the elders] are mostly living with boys. Their friends [the elder's friends] invite them, but they feel really bad because they cannot reciprocate, you know. They feel bad because their children don't want them. They are dependant on their children. Children have their own family, their own way of doing things. They don't want these intermittent

> unnecessary people coming to their houses. When you see the reality, you know life with kids! Why should she [the mother] bother? You know if the mother wants something she doesn't ask. She is the helpless person. Yes, she is dependant. Well, in India, she was on her own. She could have whoever she wanted. She cannot here because she has nothing. I remember one lady saying that she wants to move to an old folk's home. One day, she [the mother] she was saying that [she] said to her daughter-in-law, "Can I go to the old folk's home?" And [the] daughter-in-law said, "Yes, [but] don't mention this to your son." Because husbands in [and from] India, they will think that their wives are not looking after their mothers. So sometimes these elderly women want to go to senior's homes [but] their thought is crushed because of all those [traditions]. Here, there are old folk's homes where our women can go and she said, "Daughter-in-law doesn't want me to go." When the mother wants to go away, then the husband will think that something is wrong with the daughter-in-law. Otherwise, why does she want to go away? But he doesn't realize that (a long laugh) these girls are different. She [the mother] is not angry with her daughter-in-law, only she wants to be free, a free person. Her freedom is curbed. She just wants to be free. But sometimes, you know, you can't be [so you feel lonely and distressed].

Kabita further commented:

> I have seen situations where our [aged] women are thrown out of the house, because there is no use in having them [at home]. Like they were brought here because, to help their boys who were going to have their babies. [So] after the baby is born and grown up, they decided that they [the parents] need not stay at home alone. So they sent them out. And this has happened many times. We think our Hindu [Indian] society is great, but this is what is happening.

Although residing with sons (the patriarchal symbol of Indian family identity) is still practiced in many Canadian East Indian families (Desai, 1992; Bagely, 1992; Negi, 1996), in this study most participants expressed the view that the patriarchal ideology of "respect," "honor" and "position" associated with this type of living arrangement has eroded with time, acculturation, assimilation and circumstances. For example, Bonita described the intrafamilial behaviors within East Indian families in Canada as "the loss of patriarchy" (Gurumurthy, 1998). From a health and well-being perspective, this cultural and ideological transformation means the rise in loneliness and possibly chronic depression (Louie, 1998; Butler et al., 1998; Bonita, 1998). Bonita's lengthy discussion cogently expresses this point of view:

> [In India] young people will come and say, "Hi mama kaisi ho [how are you?]. Here it is not like that. See, here everything is measured in material. You give, buy good presents, this, that, celebrate birthdays. We say we are capable in our way; they are right in their way. But no, those days respect is not here, not respect. This is general. I am not talking about my children. I am talking about our culture. Because there was a voice, older people can give their voice, when they come here that has gone, right? Everybody says, mostly our aged people don't want to stay here. Why? If you ask them, they will say, "Because there is too much loneliness here" at old age. Children are going to their friends, parties, busy, and you are sitting at home. Once in a while [they go to parties with their children], that also depend upon children. You see [in these parties they are] mostly young groups, their [own] age group is not there. Sometimes small children are there and grandparents are looking after [grand] children. They [young adults] are enjoying and grandparents are looking after children. So these things are…sometimes older people don't want to go. They don't find their [age] group people. So, again they feel lonely there. Because they [young adults] are singing, dancing, this, that. So, they don't want to go. Wherever they go they find loneliness. And if they have their own friends they cannot go [to visit them] because of transport. They cannot drive. They depend upon children whenever they have time. Children have no time for them, too busy (another laugh), too busy. Again, I am telling you in general. I am happy. This is the fact I am telling you. And see old people are crying, "Why we came here?" I heard people saying those words, "Why did we come here? We made a mistake."

Amita comments further:

> Curtailment of freedom, paucity of resources, social isolation and helplessness can cause grief. [Meaning] when you are dependent on the people and they control you. You can't talk to this sister; you can only stay at my house. The freedom to move around, the freedom to interact with other significant human beings in their life. You know that ego aspect of it. So we should let go. Let go of them. I am fine, don't worry about me. If there is party at home, go there. Lack of possessiveness, you know. Don't possess them for their attention, for their money, for their recognition of you that I am the most important sibling. I really believe [that] giving is a receiving. And share the limelight with all your siblings rather than [think] if I am rich or older that I should be possessing my older people. You know! Give the leader benevolent leadership, not despotic leadership of the people who control the aged. Let them be self-determinant.

Finally, Neeta, who helped many lonely elderly EIIW in the city, expressed her opinion regarding the psychological mistreatment of aged parents in many East Indian joint family households in Canada:

> The younger people who bring them [the parents] here have no time for them. Even at a family level. They wouldn't have any time for them. So what do they do? "Hi, mom" and "Bye, mom" and these guys become housekeepers and babysitters. And that's about it. And nobody, nobody in the world can get any kind of fulfillment out of that kind of a life. And these are guys who would have been active back home leading their own lives. They would have their life, their own lifestyles. And what the young people who bring them here don't understand is [that], just because you are ten years, twenty years older than the young people, you are not ready to roll over and play dead. You have your own lifestyle [and] you have your needs. So unless you are ready to cater to those lifestyle needs, don't bring them here and make them prisoners in your own house. This is my attitude.

Whereas most participants identified "lack of opportunity for socialization" as a critical problem that causes feelings of loneliness, grief and unhappiness in sponsored elderly immigrants, Geeta described how she would feel if she encountered these social barriers:

> I am so independent, I am so strong, I am so oriented towards my goals; now if I was to be one of the women who came here later in life and is totally dependent financially and in every other way on their children, then they cannot achieve what they set out to achieve in their lives. Their hands and feet are tied, so to speak. If they want to be socially oriented, spiritually oriented, they want to be helpful, and if the children just want them to stay home and help them rather than they help the society and use their talents fully, how do they deal with it? I don't know. [But] I'll be miserable, I will be. And I think if you come later in life and you are dependent on the children and if you don't get to do everything you want to, it's going to be a very difficult situation. So I understand [one] hundred percent. That's why I am not going to uproot myself and go and live with one of my children, even if they are loving. They have asked me to do it. I will not do it because that is the way my life will be. I will go [and] help them out whenever I can. But I don't want to be a burden to them or else I don't want them to dictate in my life [such as] what I want to do, so that it is very difficult for me.

It seems that migration at a later age means to many of these individuals a loss of "self" and "control," which in the traditional Indian culture symbolizes authority (Gurumurthy, 1998) and patriarchy (Davar, 1999). In the Indian context, authority and patriarchy also come from status, position and role. Therefore, parting with their authority over household affairs, the most important indicator of the status of aged women in the Indian family (Sandhya, 1994; Reddy, 1995) can bring feelings of

loneliness, grief and emotional pain, even when these elders are living in a multigenerational living arrangement in Canada. Jeeta explained exactly what types of household activities are associated with loss of control, anxiety and possibly depression in elderly EIIW in Canada:

> Anxiety comes from loss of control, because they [the elderly parents] are used to [their] own home back in India and here they come, they have no control. They are just helpless. They don't feel they are controlling everyday life, everyday situations. They are not going to buy groceries, they are not deciding on what to cook for lunch, what to cook for supper. You know that sort of things. Someone else is telling you what to do and sometimes they may not like that. That is not controlling. They lost their controlling power.

Besides the loss of decision-making power in household matters, Sumita explained how lack of communication with children can enhance an elder's loneliness and sadness in a joint family household:

> Even people who came [a] long time ago under family class and have lived here for a long time and are receiving [old age] pension feel lonely and unhappy, because that pension is given to the son or daughter. I mean they [the aged] will give it to them because they are being taken care of by the children, right? So they don't have any money of their own. It depends upon which category you are talking about. If they are really rich people, then the parents keep the pension. That will be their pocket money and probably theirs. I don't know even in that case, will they talk about their loneliness? They may be going out more and stuff like that, I don't know. But I don't think they will complain about their loneliness. If their children are communicative, they won't feel lonely, right? So basically what you call loneliness is for people who are not able to communicate with their children. Their children are basically using them or taking care of them as their duty. If you bring your parents just to take care of them as your duty, especially in that case they will not tell their children about the feeling of loneliness. They already feel they are [a] burden and being taken care of, especially if they are single. Father or mother alive and the other one is dead. If both of them are there, then it is not that bad. They can talk to each other. I think this is especially bad for the mother. The fathers have more verbal or vocal expression to communicate.

Anita provided a cross-cultural explanation for the communication problem between generations in East Indian immigrant families in Canada:

> Because the western idea is too much on separation between young and old (small laugh). This is very hard for our Indian people. Also our women who come from India who cannot speak English, they cannot fit. So they

are "misfit" and so they feel a loss. They are impediment for children.

For Kabita, lack of communication came to symbolize lack of respect and love, and a threat to the elder's emotional security:

> I know two to three widows and they live alone, because daughter-in-laws go to work, sons go to work, grandchildren go to university, schools and they are alone, you know. And when they [children] come [home], their daughter, daughter-in-law or son-in-law or son, they expect that food should be ready. And everything [should be] on the table, or else. Whatever is possible they [the aged parents] do or sometimes they don't even do that (if they are not feeling well). And [if] they [elders] cannot do everything for them, then they [the children] yell at them, "Why the table is not set and supper is not ready?" Or even when they come, they [the children] don't talk to their parents. They just go to their rooms, eat and they don't clean their dishes, nothing. Everything is lying there. They have to do as if they are maid-servants in their [children's] house. They just eat and watch the TV or go to their bedrooms [to] talk and enjoy. So, they [the parents] feel rather below dignity treatment. They are not maids in the house. At least some love or some respect, at least anybody would [expect]. Now [if] you came to my door, just mechanically I would talk to you. That's not the way, you have to give a good smile and after all she is your mother. So she will naturally expect. As soon as you [they] come [you say], "Hi, is there food on the table or no?" She says quietly "Yaa, everything is ready. I'll set the table, come." So they eat and that's all the conversation is, no more. Right away they will go to the Internet and find out their bills to be paid or whatever they want to do. They don't care. They just eat and go away from the kitchen. Then she is the one who is cleaning everything, doing everything, fixing everything. Whether she ate or she didn't eat.

Similar findings have been observed in several earlier cross-cultural gerontology studies (Patel, 1983; Climo, 1990; Shenk, 1990; Hall, 1993; Ujimoto et al., 1993). In short, the participants associated less interaction with a reduction in social status and position, an increase in isolation and loneliness of the aged in the family context, and an increase in the likelihood of mental distress.

Unprepared events in the family/household. In addition to the issue of loss of control and exploitation of the aged woman by the married children in the household, many participants mentioned that certain unprepared events may also affect the mental well-being of this population. Table 2 shows the eight unprepared events that were most frequently mentioned in the semi-structured interviews.

It appears that most participants described these non-normative events and psychological difficulties within the familial and cultural paradigm of caregiving (Shenk, 1990; Guha, 1992; Mahajan et al., 1992; Butler et al., 1998; Phillips, 2000) and marriage (Devadoss, 1979; Abraham, 2000; Banerjee, 2002) either because they are fearful of their uncertain future in Canada or they fear widowhood and its associated severe negativism within the East Indian community (Mahadevan et al., 1992; Sandhya, 1994; Dandekar, 1996; Davar, 1999). Although my data on this issue is sparse, it is reasonable to assume that for most participants, uncertain future raised concerns about loss of status and power.

Table 2. The Perceived Unprepared Events in the Family/Household and Psychological Experiences Recognized by the Elderly EIIW Living in Alberta, 2000-2001.

Unprepared Events	Words Associated with Events	Number of Times Mentioned	Words Used to Express Psychological Experiences
Loss of life	Husband, Children, Family Members and Close Friends	120	Grief, Worry, Anxiety, Distress, Sadness and Loneliness
Caregiving	Widowhood, Old Age Related Care (i.e. Sickness, Disability, Disease and Care for the Dying)	103	Loneliness, Worry, Grief, Depression, Anxiety, Worthlessness
Changes in Marriage Pattern	Divorce, Separation, Unhappy Relationship, Extra Marital Affairs and Inter-racial Marriages	50	Stress, Distress, Worries, Grief, Anxiety and Depression
Children	Contact with the Children, Children's future and Childlessness	35	Worthlessness, Worried, Loneliness, Depression and Distress
Family Violence	Drinking and Spousal Abuse	27	Grief, Loneliness, Distress, Worry and Anxiety
Children into Drugs	Elder abuse and Involvement in Organized Crimes	10	Grief, Loneliness, Distress, Worry and Anxiety
Financial loss	Loss in Business and Other Investments	6	Grief, Sad, Worried, anxiety and Distress
Sexual Abuse	Daughters	4	Scared and Worried

All participants emphasized that the events listed in Table 2 have the potential to increase the elderly EIIWs' vulnerability to major mental distress. Sumita corroborated this view when she explained what grief meant to her:

> When something that happens suddenly, right? Just like death, sudden death. See, if it is dying of old age, you don't feel as such big grief. It is a known cause, because you get used to it slowly. But any sudden death or especially for the older women you are talking about, if their son or daughter or grandchildren, somebody has a serious illness, that will lead to grief. Or if their brother or sister [or] somebody dies, somebody especially close to them, then you really [are] going to be grief stricken.

Similarly, Bonita confessed how she had experienced grief, loneliness and unhappiness during the dying process and after the death of her husband in Canada:

> I had grief when my husband died. I felt very lonely. In the beginning, because my husband was sick, unfortunately he was in bed for ten months in the Cancer Centre. Unfortunately because he was bedridden, he was very active person and he was nice person. So suddenly being in bed as a cancer patient is not easy. That's the grief, see? Only a person knows who went through [it]. So that was a grief and when he died, it was more grief, you see, because I said whatever it was, he was there. For sometimes there comes a scare, how they would pass [their time]? I was there for him all the time, [but] who will look after me? Although my children are nice to me. I told you I have wonderful children and I am absolutely confident that they will look after me. But they have their life, you see. You cannot compare husband [and] wife relationship with them.

In India, most EIW increase their dependency on others when they lose their spouse (Sandhya, 1994; Davar, 1999) and all sixteen married participants identified loss of a spouse as a significant cause of mental distress. Vinita expressed her major fear of loss of a partner and loss of a caregiver while discussing grief, anxiety, loneliness and distress:

> Grief [is] when one person is alive and the other person is gone. Husband or wife. Then they usually are in [a] problem now. East Indians always depend upon each other – husband and wife. And the most important thing that is happening, especially with the older group, is really the grief and crying. I notice that. I never went through it so far with the grace of god. Everything is going okay [a laugh]. I can see my friends. Also nobody has got [to] that stage yet. He [a husband] is your partner rest of your life, for woman. We always believe in husband and wife as partners in life. That is how we were born, to be partner for rest of your [our] life [another laugh]. [That] is really what we are grieving for, rest of the life. [After a

husband's death] they need somebody to depend on, somebody else. Even to children, some people don't like that. Husband is more free [freer] for going out and that stuff. So they [the women] miss that, miss out that one. Lots of needs, from their shopping [in] the Indian stores. They really [have to] depend on somebody else. Traveling is [another] one. [For example], now we go to India together. See, I don't think if he is not with me, I will go to India. But I can see a lot of difference and my whole life will change. I don't think I will be happy.

The empirical studies in previous East Indian widowhood literature highlight a strong association between social sanctions that widows face in their daily lives (i.e. restrictions placed on type of clothing, diet and attendance at auspicious functions) and a rise in psychological problems (Chakraborty, 1990; Mahadevan et al., 1992; Sandhya, 1994). Here, however, the participants did not talk about changes in their diet, clothing or not attending weddings; instead they primarily discussed the loss of a support system and the inconvenience it would cause in everyday living. For example, most viewed the loss of companionship as a loss of mobility since the majority cannot drive a vehicle. Loss of mobility would result in an increased level of isolation. Because of loss of mobility, some participants continued to explain widowhood in old age in terms of being a "social burden" (Chakroborty, 1990; Srivastava, 1994; Davar, 1999; Lamb, 2000) to the extended family. Others described it as one of the causes of loneliness and in some cases depression. For instance, for Mita, widowhood means nothing but pain and suffering. Mita reflected this chronic anxiety over possible discrimination and the perceived loss of self identity and status with widowhood when she indicated that, at this stage of her life, her only wish is to die before her husband:

> If you are disabled or disfigured and can get up only with assistance [that is a different matter]. This is not what has happened to you. You can do things. I don't want any time to become disabled and they [children] have to help me. I don't want that. He [husband] is there and I am praying to god that this never happens to me. I am always praying to god, "Don't make me disabled." Before my mommy died she told me, "Tu [you] daily pray to god and ask god that I die on my husband's shoulder." My mother went like that [and] then my daddy died. My mommy went alone before my daddy, bss [okay]. Yes, I want to go on his shoulder. There, god's door is open. Our dharma says that. So at night when I go to bed I say and ask god, "I have everything." Because my mommy told me that you should go first, then you will not see his sorrow. Because if he is suffering, others will help him. If they find he has no strength, then others will do it for him. But we are women. They can't do for us. They can do, some do, but

then I won't see his suffering. This is good.

In the Indian cultural tradition, "Men used to be older than women by five or more years at the time of their marriage" (Mahadevan et al., 1992, p. 265). Many of the women in this study group are younger than their husbands. All participants are aware of the chronological age difference between their husbands and themselves. There is a greater probability that many will survive their partners. Remarriage is not an option for most of the participants. Therefore, their fear of widowhood appears to be severe.

Sometimes concerns about widowhood, loneliness and grief were further expressed in terms of the experience of negative events, comments on the age of the deceased, and descriptions of the nature of the death (i.e. natural or unnatural death). One death story was shared by Amita, whose 83-year-old father recently died of cancer, leaving her 75-year-old mother. Amita believes that the loss of family members, particularly a husband or younger members, is a major psychological issue for older women:

> I believe if I die today, I'll go happily. I mean, why complain? I have had sixty years of very [much] fulfilled life, and I am not saying I will commit suicide. I may live a long life. The only thing is I hope I never become dependent on others, where others have to do things for me. I know it is not in my own hands, but I can pray and hope for the best that I go before that situation arises. I won't say like that to older people. Because they might think I am suggesting to them, "Well, it is time to go." You know, I think I value life. I respect life. As long as one has the will to live and wants to live we should nurture that life. But my most important wish is that I never, ever see the death of anyone younger than me. And all the older people, I pray they never see the death of somebody younger than them. [When] my father died he was 83, and my biggest solace [is] that he didn't see any of us go [going] in front of him. That was a great source of putting the grief away. Yet what else can I wish for my father? We are all self-sufficient, all his children are talking to one another, and we were all there in hospital with him for two months. So celebrate that. And I want to go like my father.

All participants recognized that changes in the East Indian family lifestyle that have come with acculturation may have a negative impact on immigrant elders' emotional well-being. For some, lifestyle acculturation does not only mean changes in patterns of clothing, diet or sickness; it also includes alcohol-related spousal violence and a rise in psychological strain for the elderly parents. Many participants believe that aged

parents themselves may become victims of alcohol-related abuse in a joint family situation. According to Bonita, some elderly parents already have become victims of alcohol-related abuse:

> Sometimes their [EII families'] children are not behaving properly (laughing). Not treating them properly. There are some children who abuse parents. That time there is stress. That brings distress, when older people see that their son is drinking. I have a friend, her son is drinking. And he is such a nice boy. We don't understand. Such a nice boy. After many drinks he loses his sense and abuses [his] mother. And she is distressed, naturally.

For further clarification I asked, "Abusing in what way?" Bonita replied:

> Abusing, you see, is calling names. When they are drinking people lose their senses. They don't know what they are saying. That time she feels very distressed. And neither he will [will he] leave her. So the situation becomes difficult. [It brings] distress. It is better to leave than the distress, I think. I don't know. I have never faced them, so I don't know!

Neeta narrated a story of violence, grief and depression in the East Indian community in Canada:

> Sometimes people, particularly where there is a lot of violence in the family, women feel depression. Because there is no way out. And they go into depression for long time. They don't come out and say, "This is my case." Because here there is lot of good things, I mean good food, good house and everything you can get. So there is nothing lacking in their life. But this violence is very bad in our community. I am talking about husband and wife violence. Husbands beat their wives and they maltreat their wives. And the elders cannot do anything, they just watch. What can they do? These situations sometimes bring a lot of grief and people holding [on] through depression. If they interfere, they will be beaten.

Last, Rita explained how and why her depression started:

> It began with [a] work related injury. In 1985, my co-worker wasn't cooperating with me. That is how my depression started. Then I thought I won't be able to do anything, how to earn my bread. I was living with the family in those days. Then he was also abusive, my husband. But it was cultural difference. He comes from North India. I hope you won't let anybody know. [So I experienced] physical abuse. Look at those. He tried to break my finger. It is still crooked. And quite often he used to punch me over here [side of body]. He is a Ph.D. too. [He was] very abusive. Physical abuse, mental abuse, financial abuse and cultural abuse. Financial abuse. I wasn't given to look at my paycheque. [When] I brought the paycheque, he will say, "Turn the paycheque and sign it." He is the one

> who looked after the money. That's the way he was. From the hospital [my work place], he would take it and [I would] sign it and give it to him. That went [on] for five years when I worked in one hospital, and one year when I worked in a rural hospital. He comes from upper caste Hindu family, and he said I am an untouchable. Christians are untouchable. He is a Rajput. He was a married man and he did not let me know that. So he came to my part of the country and got married, in India. Then he took me to his place, and I figured out what was happening there. So that is cultural difference. Financially, I never had any money with me. He is the one who goes shopping and can say, "I want this and I want that," and those things he picks up. Of course, he buys $10.00 worth grocery, $8.00 grocery for himself and the rest for the family. Cultural abuse, like calling me untouchable. Christians are untouchable and religious. He wouldn't let [me] go to my church and whenever he goes with me [he] come home and hit me up. Because he didn't like. Every Sunday that was the ritual for him.

Although most, if not all, aged participants mentioned that they have made substantial adjustments in their way of life, attitudes and expectations since migrating to Canada, they have not yet integrated the concepts of divorce and separation into their Canadian lifestyle. For EIIW generally, marriage is an act of duty, a matter of moral and religious obligation and not just an act of mere pleasure or romantic love (Devadoss, 1979). In this study, most participants believed that separation or divorce would bring significant mental distress to EIIW, particularly among the aged. Accordingly, some felt that marriage breakdown is very unusual for Indian women even after they have lived in Canada for 30 to 40 years. For many EIIW elders, a divorce means loss of "family honour," and "family" is the Indian "cultural template" (Devadoss, 1979; Kakar, 1982; Morris, 1994).

In addition, the societal taboo against divorced EIIW forces many to live in unhappy marital relationships. This link between discriminatory divorce practices and mental distress is elaborated by Neeta:

> Yes, because of societal taboos. Nowadays, of course, it is not there. Taboo is not there anymore. But what choices does she [the wife] have? Financial independence? No! Where would she go? Leave the husband and go where? At any stage of life. The societal taboo you have to live [with] if you left the husband or he left you. Both times the woman suffers. So women will never, never try to get out of an unhappy marriage. Well, things are changing. If you are talking about women of my generation, no, they would never think of this. It is sad for them to even

> think of leaving the husband. So they wouldn't do that. The thought would never occur to them. They will say, "Okay. This is my ordained fate. I am going to put up with it." No, they will never, never do [does] that. Here or anywhere. That's what [the way] they were raised.

Sunita shared her own story, how she lived in deep grief from a bad marriage for fifty years just to keep her family together in Canada:

> Since my son died, this is the 12th year, [I] never seen my husband or daughter-in-law or granddaughter. They live in Northern Alberta. It is five and half hour drive. So he planned beforehand nicely what he wants to do. How he can torture me, and my elder brother-in-law used to tell, teach my husband, "You have to keep twisting and then you can survive." That advice is with him still that [if] he can torture the wife, then he will be happy. You see, some women [East Indian] will talk about their marriage problem. But their family is never broken, but my family got broken after fifty years. You know, that's my problem. I survived so [such a] bad marriage. But still I kept my family together, my children together. Even my husband used to bring other local Canadian women in the house and talk [but I kept my children together].

Further association of psychological discomfort with divorce is reflected in the interviews when a majority of the participants discussed their concerns about their children's marriages. Sumita conveyed her uneasiness with the word "divorce" when explaining the links between grief and marital problems in young families. She compared divorce to "illness" and "car accident," and strongly believes that divorce would cause major psychological trauma for aged EII parents, particularly women:

> To see their son or daughter marriage [that solid], of course you want their betterment, and when you see their marriage break down [it is hard]. Divorce or anything is trauma, even for the younger generation who is involved in it. And for parents it is the worst. It's just as bad as illness, a divorce. I think I feel like that [a pause] it is like a car accident. So divorce to me, it is the biggest failure. Not failure [but] disappointment, huge disappointment.

The correlation of family and children with the elderly EIIW's mental well-being is further highlighted in discussions concerning their children's future, contact with children, childlessness, and sexual abuse of children. A strong association between EI children's future and elderly EIIW's emotional and physical pain is expressed in the following two statements. Kunita, with a smile, explained:

> You see, we Indian mom do everything for our children. I let him know, two months I didn't eat, I was unhappy. I said "Arun, one son is a doctor and if you don't go then..." He got a job with the city [paying] $50,000. He was a very smart boy, and when he finished university B.Sc., he wanted to be a judge. I said "Judge will be difficult for you, but medical career is best for you. If you don't do what I ask you, I will not eat." He said, "Then I will try and see." After B.Sc he try, waste one year doing B.Sc, but now he is a doctor.

Leeta explained EII children's problems and the potential risk to the mother's emotional well-being in the following terms. First she reported how many children she had, and then the social problems she has avoided with them:

> See, I have three kids. By the thank of god they are good kids. I don't have a drunken one. I don't have a prostitute. I don't have a gambler. So I think you know something I showed or something I teach them. So far I don't have any [problem]. I have three kids. I have no problem with my kids, except your usual silly things that any kids or teenagers will do, that kind of things, you know. Like getting mad and that kind of things. Nothing absolutely wrong. I accomplished that, I think.

While all participants revealed that they had close contact with their children, only Punita indicated what type of emotional disorder she had to undergo in her earlier years of life in Canada and the uncertain future she is now entering into, being childless:

> Because I didn't work, I didn't do anything. I was home most of the time. I had no children; [therefore], I was feeling also lonely. Oh, all my brothers and sisters were back home. And gradually all my nieces and nephews started coming and that made me more cheerful, busy, and I felt, I can do something for them. Surely they made my life cheerful and gradually another nephew came, another nephew and another nephew came. But gradually they again moved out of this city, except this family (a laugh). I don't know what will happen.

Rita expressed concern over the safety of her young unmarried daughters from her abusive ex-husband:

> I am worried about my daughters. He might be sexually abusing them too. He is [that] kind of [person].

While most participants believe that loss of family and children is a decisive factor in producing mental distress, very few suggested that financial stress is a major factor in mental distress. Vinita explains:

> Our older people are depressed because of loneliness, mostly loneliness. Money wise, I don't think our people have problem and suffering from depression. Mostly people work. They have pension and savings. I never, at least my friends don't, have financial depression. I never see that. They are all okay, because back home we all save, keep money away for our children. That is the way we are brought up. So everybody has got some, and nobody lives lavishly. So they always save something. So there is no financial problem. I don't think so. Most people moved here at an early age and worked. Most worked all their lives.

While discussing psychological problems such as anxiety and possible money-related stressors, Anita said this:

> Here [in Canada] there is not much money problem because if you have lived here ten years you get some money anyway. You get all kinds of old age securities. So that [money] wouldn't be much of a problem.

Amita reflected back on her childhood upbringing in India, where she was taught to live with less in a country with no established welfare programs (Desai, 1985; Bose, 1988; Dandekar, 1996; Gurumurthy, 1998). She believed that this training in "poverty" has played a vital role in making her a mentally healthy woman:

> You know, happiness is a thing from within. And you can't make people happy. If I could make anyone happy, I'd be making my son very happy, you know. Like, I … make the most of your buck, you know. Because I personally feel I have never felt poor in my life, and I am not saying that I have been a wealthy person. And that training in poverty has really helped me grow. [I believe] that no matter how poor you are, you are not poor.

However, most participants think that loss of control over their own finances will bring mental distress, in particular, when their offspring take control over their finances such as the Old Age Security (OAS). Kabita, for example, said that "Losing the entitlement to this income brings unhappiness and pain." Wanita explained that one of the major problems with EI elderly parents is the "money problem," particularly money management:

> Our people don't like to go to [a] Senior Citizens Home. It is the money. Family don't [doesn't] want to spend that much money. Again money is the problem. Because what they get for old age pension, they don't want to spend on them [elderly parents]. They want to spend on their own. If they put retired people in seniors housing, they have to pay for them. That is why they don't want to spend money on them. Because they may be making money in old age pensions, they are getting $1600 easily. So they are not going to spend that $1600 to put them there.

Kabita summarized the meaning of loss of financial authority and the related emotional strain in elderly EIIW's daily lives:

> Some ladies say [that] I have no authority to even have a cup of tea on my own. They will tell me only one cup of tea in a day (in a choked voice). It is very expensive to take three cups of tea in a day. It is sad, isn't it? About the medication also. They [children] for the sake of expenses don't give medication properly. Clothing also. In a year, they may be having three sarees to wear. Normally they don't take them [the elderly] out. Of course, if you don't understand English, how will they take you to the movies with them? Or it is not proper to go with your children to a movie with your son and daughter-in-law. Or there are so many places, so many weddings, so many parties, our older generation don't go, and that is why they don't take them. But if there is an Indian wedding, they take them. At that time they have to make a show that we treat our mother very well. So that is why there is one more extra sari for them to wear outside. That's it.

Anita added that, in Canada, loneliness, depression or distress will arise in elderly EIIW not only because of loss of control over their finances, but also because of certain attitudes and behaviors:

> All these recreational [activities] around here that are available to most Canadian elders are not available to our elders. Because it costs money and our children don't want to spend that money.

The interviews propose that the strain from loss of financial control negatively affects the personal behavior of many elderly EIIW in the Canadian context. This result contradicts earlier assumptions that this population has adjusted better to social indices such as family, financial stress and unprepared life events in the diaspora (Patel, 1983; Rait & Burns, 1997; Ananthanrayan & Cochrane, 1999).

B. Personal Issues and Mental Distress: the Gender Reality

All participants mentioned that personal issues such as withholding one's negative feelings, not being assertive, and lack of physical activity are equally important as major contributory factors to mental distress and its symptoms. Some participants suggested that everybody has negative feelings, but not everyone goes through an emotional crisis. All participants described that withholding negative emotion is an unnecessary cultural practice and believed that such practice is a key determinant of the EIIW elders' mental distress in a foreign land. As Lalita in a disappointed tone said, "Our ladies suffer unnecessarily from such behavior [withholding negative emotion]." The strong

association between personal behaviors and mental distress is further explored below.

"Our elderly Indian women won't talk about it": Indian Feminine Characteristics. It is evident from the rich field data that withholding one's inner feelings is a key characteristic of elderly EIIW. Two participants described the elderly EIIW's pattern of sharing emotional and psychological problems. Sumita cautioned that feelings such as loneliness, grief, and other emotional suffering experienced by the EIIW elders will mostly go unnoticed:

> They [the elderly EIIW] would accept it [loneliness] as a fact of life and deal with it. I mean most of them but I don't know. Some of us who have been here, gone through western way of living, probably will express it. Because when you express it you get over the…you get some kind of solution to it, right? If you don't talk about it at all, you don't get out of loneliness. So people like me, see I have lived here for 34 years. If I felt lonely, probably I will talk about it and tell somebody and try to get some kind of treatment or whatever is the solution for it, to get out of it. Generally, I would say ninety percent of Indian women would not talk about that.

Leeta commented:

> I know eighty percent of ladies won't show up there [in a support group meeting]. Even if they show up they won't tell you that they have some problem. For example, [if] they don't talk, how can we get any clue from them? Sometimes [there is] violence in the house. They [children] may beat the mother or mother-in-law. But they won't tell anybody, you know. I know that young adults have done it, which their mother doesn't want to reveal. Their younger siblings might have told to other kids like that. They won't tell you, unless they told the doctor. Who knows? Personally, I won't ask. I know one of my friends was beaten by her son, and her daughter told my daughter. But I won't go and ask, "Did this happen to you?" She probably won't like to tell that. So, I wouldn't even ask that.

Because of the culture of patriarchy and unfamiliarity with their own rights, Sumita believes that most elderly EIIW will never communicate their negative feelings:

> Because they don't think it is their right. Just like, you know, when we grew up and all we were [doing is] working at home. And [we were] doing all the [house] work, and the men come and you have to cook, even if it is 10 o'clock, my mother and so. This is assumed of them. So probably that is what I am saying that, if they have come from India at later stage and they are here, I don't think they will talk about loneliness. Whereas a person here would, a person grown-up [here] probably would complain about it. That's what I mean, "They won't complain about it."

Kabita brought up the issue of lack of intrafamilial communication:

> When I ask "kai se hai bhanji? ["How are you, sister?" She replies] "Ki day karoo, mujhe tu merji se gulam ho gie hun na.[On my own wish I have become a servant.]. Yea rahan hi padata hai [I have to live here], karna hi padata hai [I have to work here]. Bachoo ki seba karana jaou main [my duty is to work for children]. Mere ko bhi meri pati bhi nahi hai na [I don't even have my husband, okay]. Tu mujhe ko sahena padata hai [So, I have to tolerate]. Mai unco kuch nahi bolti hun [I don't tell them anything]" (cried while sharing this story).

Punita provided three explanations for such behavior:

> Some may express and some may not. Because they must be thinking that they will be hurting their children or their family. And then it's our culture not to talk about ourselves, not like local culture. They don't want to disclose what they are going through; mainly because they think the family will be hurt. [For example], well they [the parents] are going and exposing to other people that we [children] are not doing anything for them. That's another thing, they think that way. And number two is "Why should I talk about myself? Why should others know about me?" You know, once they disclose something from here to there, there to there, everybody will be talking [that] so and so said such a thing, so and so [is] going through all this. They don't want that. As I said they are just miserable in their homes, you know, just lying down. Some people can't do anything, they are [so] miserable at home.

Leeta gave another possible reason for such behavior:

> It is always like that. There are opportunities or resources. If you need help, then get it. But our people won't go for that. They think it is below dignity. They are [too] proud to go and get help, I think. If somebody's husband is drinking or is gambling, they think it is not good to tell the friends. That's what I think.

Neeta confirms the saliency of Indian feminine practice with regard to sharing of inner feelings or personal issues when she says "Don't spill your guts to outsiders":

> One time one of my friends asked me, "You know, I got this one certain organization I [was] volunteering with. I got this grant to appoint somebody, hire somebody who is on welfare. Do you know of anyone?" I said, "Believe me, if any of my friends are on welfare they would not let me know (a laugh)." That's the kind of cultural background I am talking about. Because [it] doesn't matter if you are dying, you would not share it with somebody. It has to be really [an] extreme case. But my generation [would say] "Unh, no" [you don't talk]. So yes, some of them do feel lonely, not so much lonely as being ignored.

Sita explained:

> See, the thing is we mostly, East Indian ladies, like spreading. Anything happening we like spreading. Say one person will tell another, "Oh, she is depressed," and that goes to the other person, you know. And it is like that. I think here for this reason most of the problem is not coming out. They are not telling or talking it out. They keep [to] themselves.

Babita believes that elderly EIIW avoid sharing information on personal problems to avoid social stigma:

> Suppose a family has some family problem, problem between the husband and wife. According to the Indian custom, most women won't say that to others. They don't want to. Some people will look down upon them [saying], "Oh, those people they are having family problem. It's not a good family." They will find fault. Instead of helping you and giving you advice they will find fault.

Bonita paused momentarily and then admitted that she withholds her unhappy feelings because she doesn't like to be labeled by others as a "weak person," meaning a person who "lacks internal strength or security":

> Whatever to suffer I suffer. That is the bad habit of me. [However], I don't want to, I don't want anybody's pity. That is, sometimes people pity you because [you are] "bechari" [helpless]. That part I don't like. Mostly, I am very independent [in] nature. I don't want anybody to pity you [me]. It is not my habit. It is not right, I understand. Sometimes people come with love and affection and sympathize with me. I have very good friends. Nothing wrong in that, you see. But I am made up of like that! What to do? I don't want anybody to know. That's my nature. You see, because I have seen people, they pity you and then they talk behind you, right? It doesn't look appropriate to me. They will say "bechari hai" [helpless one] and then they will talk. If you say, then they will take [it] in wrong way. But as children they will misunderstand. There are so many things you know…I think you understand very well (a big laugh).

Sumita said that she did not share her personal anxiety over possible Alzheimer's disease with close friends because of the unnecessary gossip it would have created:

> There are some issues I do not share with others. So what I am saying is that I feel they [friends] may think I am over-anxious, you know. I didn't want to unnecessarily panic them or they were worried too that they wouldn't do it. So if I do, that means it must be bad. I don't know why I didn't tell. Let me see why I didn't want to tell them. I didn't want [to] unnecessarily create [a] topic of conversation because it becomes a gossip like thing. You know what I mean. I am thinking just that reason.

> Otherwise I talked to my doctor and I talked to my daughter, my husband. They both laughed.

While most elderly participants linked psychological problems and lack of communication in elderly EIIW to patriarchy, avoidance of unnecessary gossip and lack of power, others acknowledged that they do not share their negative emotional feelings with their children because it would make their children unhappy. They believe that there are some children who haven't altered their traditional lifestyle and values in the face of the reality (Sokolovsky, 1997, p. 264) of western civilization and ideology. They look after their parents very well. Based on this parent-child relationship, Bonita indicated that:

> The feeling [loneliness] comes. I cry, but I don't cry in front of any guest. I still do [cry], sometimes if I remember [my husband], not in front of children, because they will be unhappy. [I cry] because I miss him. In the bedroom I cry. It is always there. You see, because everybody needs [a] partner, right?

"Our women will not assert themselves." Not being assertive is another individual characteristic believed to be prevalent among elderly EIIW within the family context. However, most participants assume that this behavior is limited to first generation immigrant women, particularly among their own generation, and may not be found among the younger generation. Leeta mentioned her assessment of elderly EIIW's character:

> Our people are good in hiding things, you know. Some women may hardly go to see a doctor or somebody. They say, "That's my fate." That's what they think. Occasionally they may tell their husband, "Let's go and get some help." They may tell the doctor. Our women won't tell anybody openly. Future generation, I mean the younger ones; they may be little more open. Older people think, "Oh, okay, that's the way life is."

While some participants described such behavior from a "fatalistic point of view" (Naidoo, 1985, 1992), others connected lack of assertiveness to their past socialization in a patriarchal East Indian society. These women strongly believe that, as a result of not behaving assertively, elderly EIIW suffer from loneliness, isolation and grief; they also increase their chances of experiencing depression and mental distress. Jeeta, who has encountered many such elderly EIIW in Canada, primarily blames the patriarchal Indian system:

> I think it is all individual cases. [But] you should speak up your feelings. If they are not willing to understand or not wanting to understand your problems, you should be able to speak out. Not speaking out, I think that is the culture. [Again] the culture is back home. I think it is all women [who] face these problems because women are subdued by men back home. Men were the main breadwinners. They brought the money to control the house, so that means they have the control over the whole house. These women do their work. I think women work ten times harder than the men, even though they bring the money. But they [women] are not appreciated that way. So you are controlled. Because of their low employment status back in India, they are afraid of being pushed out. And they have no means if they are pushed or divorced or whatever. And society will not accept that fact. So they will stay home and accept everything, even though you don't like it. Because you know your society will not accept you if you are separated or divorced. Because your family won't accept you and your society won't accept you, and you have no employment. Where do you live? So you are stuck with that. So that culture made you feel that you are subdued, you don't say anything. So I'll put a good face in front of you. But you are not; I am not very happy inside. But the people here, they are open. They will say, "No, I am walking out," and the men know here too. I think that's one big problem.

The data show the complex relationship between personal issues and psychological problems experienced by the elderly EIIW. Most participants, however, assume that these issues may become more severe with widowhood, lack of leisure activities and transportation, and Canadian weather. Some of these assumptions are elaborated below.

Leisure Activities and Psychological Distress: Several participants revealed that lack of leisure activities is another problem that is generating mental distress among elderly EIIW. Comparative analysis of the interview data, however, suggests that the nature of the leisure activities and the participation rates of elderly EIIW individuals vary based on their access to facilities, economic condition, family background, transportation arrangements, and health. Participants mentioned hobbies, travel, shopping, exercise, religious activities and volunteer work as major pastimes that many elderly EIIW undertake for their psychological benefit. Amita further pointed out the importance of pastime activities for elderly EIIW in Canada:

> I think being involved, involvement is very important. For instance, I am involved not [only] in my own family, I am involved in the whole world. What's going on with our election? What's happening in the United

> States? So being involved is very important… [The elders] just have to recognize the importance of peers in their life. You know how some of us get in a rut: "Oh, I am not happy. My son is this. My daughter-in-law is this." They can have [a] new outlook.

Vinita recommended that elderly EIIW have leisure activities to break the feeling of loneliness, the key determinant of mental distress among this population:

> If you don't do any activities, this feeling of loneliness can last a long time. They [people] have to work hard. Like me, I have a glass of milk, go to the shopping centre and walk around. You could do that if you can't drive. You have to work hard, that's all. I read. So we can read and spend time. Some people won't do any of these things. That is the thing I am saying, people must try themselves to work it out. If we have something, I think we have to try ourselves. I think people are learning. The first generation who [that] came here are different. The youngsters will be different.

Despite the benefits of leisure activities, particularly exercise (Cress & Green, 1996; Bryan et al., 2003), Anita criticized some English-speaking elderly EIIW for contributing to their own loneliness and other psychological problems:

> Those who can, who have degrees, who speak good English, but still because of weather they are sitting at home. They are themselves creating this situation not to go and participate in things. You should interview them. Like here, in the university gymnasium there are lots of programs for seniors, I mean lots. Our people have the tendency to hoard money (a big laugh). For whom they are keeping that money, because all elders are getting lots of money from the government. And they will make frequent trips to India. Some do go [to other places], they make contacts [with their friends] and they say, "I will come." [But they don't do exercise].

As in earlier immigration and environmental stress studies (Kim, 1987; Berry & Kim, 1988; Kinzie et al., 1990; Krishnan & Berry, 1992), many elderly participants added that the harsh Canadian weather can act as a barrier to leisure activities, thus increasing the emotional strain. Kabita explained:

> Also climate, it is very cold in Canada. They cannot get out of the house. They cannot walk, because the roads are very slippery and temperature is below zero. So, in sub-zero temperature it is hard for them to walk. And that is why they [the elderly EIIW] feel [loneliness]. It is painful for them to stay home.

In addition to the weather and lack of transportation, most acknowledged that widowhood and a lack of English may deter many elderly EIIW from their choice of

leisure activities. Many participants had such experiences. For example, Bonita compared middle-aged EIIW and aged EIIW to make her observation clear:

> You see, I feel your life will be different than ours. Because you are here since your semi-years, grown up here, know everything, drive. Many old people don't drive. I don't drive, but I mostly move around in buses. Maybe our age, dress, [and] language are problems. So they don't have confidence in them. That makes it [hard for these women]. They don't want to come out. Yes, that is my assumption.

Neeta shared her views about leisure activities and mental distress, comparing elderly EIIW on language fluency:

> Let's say your family doesn't have time for you. If you had no language problem, you can at least get around with your neighbors. Just talk to them or do something or go places with them. You can find your own age group and get involved in some activity. Get out of the house sometime, even after you do all the housework. But if you don't know the language, you don't know what to do. So loneliness comes and creates depression, a withdrawal. But they will not share that information. No, they won't, no way they will. There is no communication. Who do they talk to? That's [why] they are going in circles.

Although the relationship between psychology and leisure activities of elderly EIIW has not been studied in Canadian sociology, it is clear from the current data that, for these individuals, personal leisure activities are important to their psychological and physical health.

C. Health Related Issues and Mental Distress: The Aging Reality

Arising from the change in lifestyle due to migration, acculturation and aging, in this study participants explained that health and illness, the thought of dying and death, and disfigurement in old age can cause emotional problems and possibly mental distress. Their discussions documented not only what types of disease or illness cause anxiety, loneliness, worthlessness, grief, emotional depression or distress, but also the influence of such short-term psychological problems on the development of certain disease experiences.

Health, Illness, and Psychological Distress: Although participants saw themselves as relatively healthy individuals, many health issues existed. Neeta's comments are typical of those participants who are experiencing minimal health

problems:

> You know, surprisingly, most of our elders are healthy. I don't think that is a concern. The biggest thing probably people would have is maybe hypertension or diabetes, but nothing major. Arthritis may be another weather-related thing. But I don't think health is a major concern for our older people. Our lifestyle! Again if you are a vegetarian, it [vegetarian diet] has a built in protection against all these things.

For some elderly participants there was a clash between emotional problems and social environment, leading to the development of disease. In particular, diseases such as diabetes, arthritis, thyroid problems, CAD, hypertension, and Alzheimer's disease emerged as a topic of discussion in the category of degenerative disease and psychological problems. Among the above-mentioned conditions, diabetes and arthritis were thought to be the most common experiences among this group. Some individuals mentioned that they have diabetes and others arthritis. Only a few talked about their thyroid problems, hypertension, or anxiety over Alzheimer's disease.

Sabita's discussion about worries [distress] and conditions such as diabetes is very similar to data noted in other cross-cultural distress studies (Surwit et al., 1990; Chen,.1997; Moneda & Gibson, 1998):

> I got job, diabetes because of anxiety, worries. Like when they said to my husband, "You got to go to Hyderabad or Japan or somewhere." My husband said, "If I go there, my daughter's study will spoil." So some of our friends – he got very good friends – said, "We will look after your daughter." The other friend said, "No, no, no. That's no good because your daughter is sixteen years old. You don't know your friend [is] not going to watch what she is doing outside. Some people talk like that. If you hear everything, you [will] feel sorry." So that time I got too much worry [worries] and I was only very young, I got diabetes about 30 years of age. I did eat, but I was crying, I was thinking how to get this problem solved. I got all over big, big boils. I was so worried. Especially my mother, husband also was worried. I can't sleep. Now also I feel sorry, still today.

Sunita explained how her daughter, who had a thyroid problem, also lost her voice because of severe emotional strain:

> My husband will get mad if my daughter went on the phone for a little while. She had a thyroid problem from wrong medication. For anemia he gave something which he shouldn't have given, the doctor. And after years she got thyroid problem, and she was talking and her friend was

> talking because thyroid is emotional. So he scolded her. It was about one o'clock [in the morning] and her friend was talking and she wanted to talk to somebody, and he got up and opened her bedroom and scolded her: "You don't belong to home. You belong to hospital. Go to a hospital." She, neither I, knew that thyroid can create emotional problem. I didn't know that. And he literally threw her out and she took taxi. She called the taxi and went to the hospital and she came from the hospital for the weekend. Gradually she lost her voice from all these stresses.

While some mentioned the association between emotional problems, disease and symptoms of disability within their group, others explained how illness or risk of disease can cause chronic emotional problems. Namita, for example, explained how she tries not to let her mental worries about diabetes, arthritis and blood pressure become chronic:

> Now I have pain, you gave me some relief. I go to the doctor, sometimes he makes me feel better and sometimes nothing happens. Yesterday, I went to the doctor. You see, it is very cold here. Therefore I have severe arthritis. I can't walk. I can't even go down [bend down]. That is why I am sitting with pants and shirt. Your own treatment you have to do more than the doctor's. You know what treatment makes even a little difference. After I get up in the morning, I keep the heating pad [on the couch]. So when I need it in one or two hours I can use my heating pad. Like there are many types of anxiety, there are many types of sickness also. Now I am suffering from pain, blood pressure, mere ko sugar hai (diabetes). If everyday I worry about it, then I will be in charpai (bed). That is why I have decided not to think about it and everything will be all right.

Sumita described how her anxiety increased at the thought of having Alzheimer's disease:

> I went for Alzheimer's test. The basic reason was I had done my further studies. So my memory was excellent. Of late I find I am not able to remember things and not able to do certain things I want to do, but forget. So I started wondering, and I read in the Time magazine that you have cures if you find Alzheimer's disease you have. If you start the treatment quickly, you can stop it at that stage. I said why should I wait when it's really bad and totally lose my self respect and dignity by being somebody else who I am not? So I went and asked my doctor, "Do I have this?" Then she said, "Look, if you want reassurance, I'll send you for an Alzheimer's test." So I went. They tested me. Everybody laughs, my daughter laughed, my husband laughed. I said, "I just wanted to get this done." And so I did. Then it reassured me that I don't have any.

Thought of Dying and Death and Psychological Distress: Thoughts concerning where and how to spend the last stages of life (Devadoss, 1979; Pillai, 1985; Mehta et al.,

1995; Dandekar, 1996) were also perceived to increase the risk of mental distress. Two of the most frequently mentioned concerns of this stage of the life cycle were disability (popularly known as "dying" in this study) and death. For example, several participants commented on the issue of "family service" (Deppen-Wood et al., 2000) or caregiving, particularly concerns about who would nurse them until death. Anita described how caregiving during disability and negative attitudes towards death can bring anxiety and distress:

> Health and dying (laugh): When they [elderly EIIW] have stroke, they think, what will happen to them? If they are dying, what will happen to them? How will they be treated? Will people [family members] look after me [them] or not? Some of them don't want to listen to the doctor's advice. They don't believe in that and they don't do what doctor says, and they take things into their own hands. I mean, they don't find the support they want. The doctor's advice they don't like. But they think there is some sort of maybe homeopathy or allopathy. Or this or that or maybe [a] miracle, you never know. So their health problem causes more anxiety. And they don't want to die. Nobody wants to die [but] everybody has to die when the time comes. Because they want to live to do something for themselves, for their folks [kin, family, lineage, clan or people] or for friends. One of our friends here, she had so many heart operations. Now she was trying to have [another] heart operation and so many complications. She was trying to change three valves in the heart. She wanted for the change of heart, and [she] had to wait for many months. But because of this situation here [in Canada] and quality of care and the environment of health care and things like that, the surgeon who was to operate always postponed it. Eventually she died. Although she wanted to avoid death, she couldn't.

Despite the availability of organized health care services for the aged in Canada (Saldov & Chow, 1994; Northcott & Milliken, 1998) and community services (Mays, 1983; Atkin, 1989; Padgett et al., 1998), Punita explained that for some elderly EIIW dependence on outside assistance when physically disabled brings "big anxiety" and distress:

> My very good friend, who is blind, has diabetes; she has got stroke and barely she can't walk, and she stays home alone in the day. She is very lonely and she cries sometimes. On the other hand, she will not let another person to come and give her company for the whole day. No, she doesn't want. One reason is she can't go to the door and open. Number two is it is an insult to her that she is asking somebody to help her out. She's got children, but they are not able to help her. They do help her, whatever they

> can do. But this kind of loneliness is different. Or she doesn't want to be in the nursing home. But she doesn't want to tell me…She is just old. And then the daughter wants her to get somebody to come and give her food and give her bath. She cries, I believe. She says, "I have a daughter-in-law, two daughters-in-law, and they want me to be bathed by somebody else." She has been here long, maybe as long as I am. Maybe thirty years. This is anxiety, no doubt about it. It may be distress also.

Bonita analyzed the health care and the preferred place for dying of many elderly EIIW and men in Canada:

> Everybody is worried about their health. When they are ill what will happen to them? That brings anxiety: "I will be ill, who will look after me?" Whether I am invalid or not, the same thing. That is the main worry they have. They worry because the facilities are different. What facilities [would] we have at home? I am sick, suppose. This is [an] example. Nobody is at home, you see. Especially in this country, in India, we have our servants who will give you a cup of tea whenever you like to eat. She will come and if you are not able to get up, she will help you to get up. Whenever you are not able to get out, she will help you to get out. If you left home alone, then you can't do that. You have to do [it] yourself. And if you are able to do this, okay. But when you are not able to do, death comes. That's the thing we are worried [about]. What will happen to me if I am sick, who will be there? Though we know that otherwise we can go [to the] nursing home. Here we have the facilities, but people don't like that (a small laugh). They don't like nursing home that I can say. Because I wanted to do that to my husband, but he cried and said, "No, I want to be with children. Nobody wants to die in the nursing home. Home is home." That causes psychological problems such as anxiety and worries.

The above examples highlight the linkage of major social events of the Indian life cycle, such as "honoring the dying elderly" (Devadoss, 1979), with anxiety. The narratives below demonstrate some participants' actual concern relating to old age, disability and death. Geeta explained:

> We have taken care of quite a few aspects. But old age and ill health, I think, is the only part of our life that we are thinking of a strategy of how to deal with it. And that's the thing that we are thinking on those lines. [However], the only worry of our lives is ill health. That's about it and the eventual dependence that comes with ill health.

Sumita shared her feelings of anxiety over the prospect of disability and dependency:

> At that age in our age group, probably we are anxious about, for me now, when I think about it, I am anxious that I shouldn't be a dependent. Now I worry that I shouldn't be at 60, 70 or 80, I shouldn't be bedridden and be a burden to my children. But that is not anxiety. You might say inherent

> anxiety, but nothing out of control. Again, I pray that if that is what is meant to happen, you have to deal with it. But it doesn't mean that I don't worry about it, I do. Periodically, if somebody has some pain or if my knee hurts, or if my back was hurting and I couldn't move, kind of got caught or something. I have some arthritis. So that is when I thought, "Oh no, I am not going to be like this forever and be a burden to somebody."

Although most of the participants were aware of the association between negative thinking and mental distress, some remained apprehensive about their future. These participants felt that they might not receive proper attention from their children during their last years of life. This "transplanted" traditional Indian way of cultural thinking of the future is found in Vinita's interview data:

> I also think I am going to be dependant on my children. In India, we always see like this in our culture. We have our children. We help them in study, growing up. We spend all the money for the kids, and also for their future we keep money. For their safe future we keep money. So what their duty is, when we get old they are supposed to look after us. This is how it is going on there. Here, it is not that way. Over here, we have that feeling [wondering] if kids want to do that or not. I don't know if the kids will do that. Not very many kids are going to do that. This is the kind of thing that makes me feel like; will my children do [this]? If they don't do then it will make me feel really sad. It is depression, right? If this happens then we will be in real trouble, real depression. That is scary part.

In addition, the results of this study suggest that uncertainty about the performance of traditional Indian death rituals in Canada may have a negative influence on the mental well-being of elderly EIIW as well. Anita explained:

> They [elderly EIIW] don't talk about death rituals. But they never rule out the possibility of a cremation. Who is going to do it? How it will be done? If their husbands die, who will look after them? Those things bring fear. Anxiety of old age brings fear and anxiety. Nobody talks about it. This is what I wanted to bring in. Nobody talks about them.

Vinita added:

> See, now I can function [and] if something happen to me, old folks homes are there, auxiliary home is there. Over there [in India] we never even let people die in the hospital. We bring them home. Only very rarely we take people to hospital. This is the big difference over there and here. There are some changes over there too. Another one I was thinking about is even back home, if somebody died we do everything at home. Here, if anybody dies you really never see the body. They take it to the moratorium. This grieving is another one. I don't know in North India how it is? In Kerala, we always keep the body at home. People all come home, cry and

> everything they do. And then they dispose. And here, you never see the person right away and body has gone to the moratorium and you go once and two times and see, that's it. So the grieving time is not there. So what you say [is it] scared? Anxiety I can say, lots of difference.

This section describes the experience of stress related to dying and death among elderly EIIW, a topic that has rarely been sociologically explored in cross-cultural feminist gerontology. The analysis shows that the death ritual is a significant event in an elderly EIIW's final stage of life (Nayar, 1994), and the thought of not following that step can cause emotional problems, particularly anxiety (Ramamurti & Jamuna, 1987). The elderly EIIW participants seem to believe that erosion of traditional Indian cultural symbols and of the tradition of family caregiving to dying elders will make this population vulnerable to disability and mental distress in the Canadian context.

Disfigurement in Old Age and Psychological Distress: While the process of death can cause much anxiety among elderly EIIW, the participants also perceived that certain types of disease can cause mental problems. In particular, they perceived that diseases having a social stigma increase the risk of negative emotional feelings, because they affect the individual's self (Ramamurti & Jamuna, 1987) along with the family (Shirali, 1998). Unlike previous social psychiatry and disease studies (Zambrana & Britt, 1995; Holm & Scherubel, 1997; Rhodes & Goering, 1998), in this study the most frequently mentioned culturally-specific stigmatized diseases were clinical depression, vitiligo and eczema, and not HIV/AIDS or alcoholism (Antai-Ontong, 1997; Chen, 1997; Louie, 1998; Shin, 1998).

Sumita used personal examples to explain how these diseases have the potential to affect the everyday life of the victim and the family in negative ways:

> What other thing can cause depression? Finding out if I have other disease like even vitiligo -- it is called leukodermia in India. Those things have a stigma. If I have, I would feel depressed. Not any disease, only certain which are stigma. Like cancer won't cause depression. Not for me because I feel that's okay, it will end, and I'll die (a laugh) still dignified or whatever. Skin disease like vitiligo, eczema and things like that will bring depression. With Alzheimer's you won't know. I won't know. But if I had it, then probably I will be depressed for a little while. But if I can know and go for test and find a cure for it and deal with it probably. So I don't think that would. If I got vitiligo now, I think I would.

> There was a chance that I was going to get. Because I had a burn in my hand, I poured oil. And so these thing came [and] I thought this was going to spread all over me and I won't be normal. For a while I was anxious and depressed. I was thinking that I won't be able to go to my daughter's graduation. I went through a period of depression. I don't know if it's depression or anxiety and depression too. But that depression is slightly different. I didn't get to the point of no talking, or like that. If it got worse, like if it became like that like my friend's mother. If it had become like that it would have been difficult. It would have been hard. I know my cousin's father-in-law has that, and he is totally depressed. He is 82 and he's got it now all over, it's kind of pink and red on his face and his head, everywhere. So that causes depression, it is trauma. You fear it's going to spread all over and disfigure you completely. It is not physically but the emotional part that is the hardest. How it is going to affect the children, how it is going to affect others when they look at you. For a child, for example, to take your mother or father who has vitiligo to graduation or something like that and explain to everybody why she looks like that. That's hard. Luckily I didn't. I poured hot oil, you know, so it was third degree burn. It was all over here. All three skin layers came out. Oh yaa, I am still deep-frying (a big laugh). It was hard. But I am not a person who easily assume that it's [going] to happen again. It's just a one-time thing. It can happen to anybody.

Though this theme was not explicitly shared by many, the subject seems to communicate the perceived association between disfiguring disease in old age and psychological strains among Canada's elderly EIIW. In addition, there was considerable agreement that clinical depression, the most common type of emotional deformity, is strongly associated with the mental condition of aged EIIW. Babita shared her opinion about depression and mental problems:

> To me, my honest opinion is if Indian women are depressed, they have some mental problem. Very seldom they speak out. That is our custom, eh! We hide it.

Anita explained:

> [Depression] is psychological, you know. What kind of depression otherwise [do] people have? Sometimes they do [suffer], sometimes they do tell that they are depressed. They feel afraid. They are frightened because they don't know what will be the outcome. They have no control over that. I guess they think they have no control over this ill health. Indian women don't deal with depression well themselves. They won't help themselves. This is repercussion of family situation, because they think of the family.

Generalizations from this finding may be limited because of the exploratory nature of the study. Nevertheless, the results are encouraging as they indicate that elderly EIIW are much more likely to experience emotional strain if faced with a disease that has a social stigma attached, a pattern seen in several studies of women in India (Kakar, 1982; Weiss et al., 1986; Chakraborty, 1990; Shirali, 1998).

III. Perceived Consequences of Mental Distress

Analyses of the causes of mental distress and its symptoms are, of course, significant in their own right. But it is not clear what effect negative mental distress has on EIIW elders themselves. In further analysis of interview data, it was apparent that the participants were evaluating the effects of mental distress from the health and wellness approach (Freund et al., 2003). Therefore, various health and illness experiences, and perceived fears of dysfunction through the loss of internal self-control, influenced the participants to interpret mental distress as the last stage of the common psychological problem cycle. In particular, experiences of disease, insomnia, dizziness, thoughts of suicide, minimal medical service utilization over time, and death are thought to be outcomes of complex mental conditions, and social, cultural and individual-moral factors. A few of these factors have been discussed in earlier cross-cultural gerontological studies of western societies (Osgood & Malkin, 1997; Shepard, 1997; Butler et al., 1998; Kabache & Bertiere, 1998; Ananthanarayan & Cochrane, 1999), and in a few gender and mental health studies (True, 1995; Hirayama & Hirayama, 1996; Yee, 1997; Padgett et al., 1998).

All participants indicated that everyday stress and mental distress, if not prevented or managed adequately, can have long-term health consequences for elderly EIIW. The health effects discussed in this study can be categorized into three broad types: (a) physical health, (b) social health, and (c) mental health (see Figure 7).

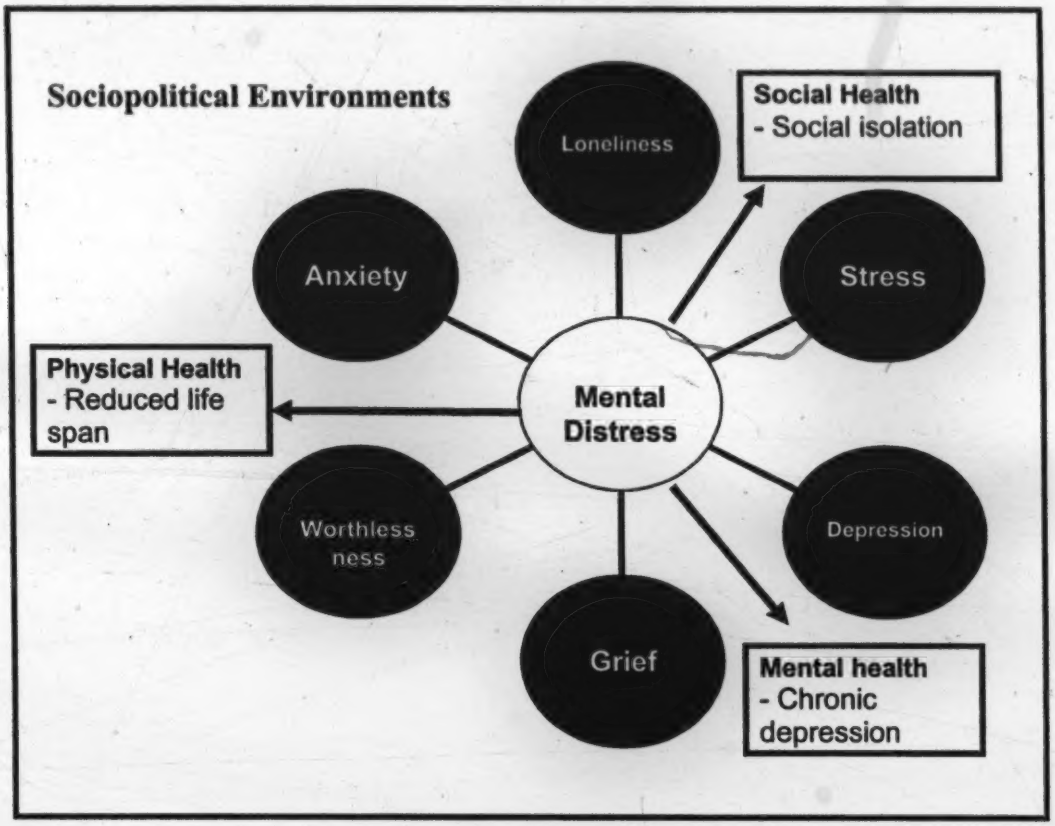

Figure 7. Perceived Consequences of Mental Distress of Aging EIIW.

A. Mental Distress May Affect Physical Health

Physical health in this context means the human body that experiences health trauma from prolonged psychological abuse or acute mental stress. The effects of mental distress on organ systems of the body have been extensively studied through biomedical research (McCabe et al., 1990; Danesi, 1993; Dillmann et al., 1993; Hubbard & Workman, 1998). While most medical and health system approaches suggest that mental distress can alter or introduce new diseases in normal persons, the participants expressed a belief that everyday stress and mental distress will not only bring illness but will reduce the longevity of a normal person. Sita explained the relationship between mental strain and reduced life span:

> Human beings are made to be busy, right? That's what my thinking [is], you know. And if they are not busy and [they are] lonely, something is lacking there, right? I can help them to get away from that – go for a walk, or bring them here and talk. If they are lonely, the life span will go down. Because we are made to toil, depression will reduce life span. It is the side effect of depression. Don't you think so? You can't answer (a big laugh). Your mind won't work hard. When I am seeing you my mind is working. Actually, I am interested in working in plants [and] needles so I never get any shortness of life, I think.

Punita explained with deep fear the consequence of psychological strain among elderly EIIW:

> Sometimes they [the elderly] will talk. They say, "I am lonely. I have nobody to take care of and what am I going to do? What happens to me at the end?" It means, if he or she goes [on], deteriorating and deteriorating and nobody to care. So that's where they are worried. They, some of them, don't believe in going into nursing homes. They demand that their family should take care of them. And if that doesn't happen, then they are grieving and upset and all these things come. Some of them don't want to stay. As I said, "I have got a daughter-in-law and she is not trying to bathe me and I have to get somebody else." Just like that. I have so many children and then I have to go and live somewhere else. When that feeling is there, they just fade away. Every struggle they live, and when it gets more and more some disease will take over and they will die.

The participants mentioned that mental distress among elderly EIIW may also affect their utilization of health care services. Taking depression, a symptom of mental distress, as an example, several participants from diverse backgrounds discussed the western health care utilization patterns of some depressed elderly EIIW:

> I don't know if anybody even go and see the doctor. That is also very rare. They think it is a mental condition or what.
>
> Our Indian women will not go themselves to see somebody when they are suffering from distress. Never! Yaa, they will talk to their friends and sometimes to son. But they talk a lot to friends.
>
> They [Indian women] hope if the situation changes then they will get out of depression. Well, they go to their very close friends. If the situation is very bad, sometimes they do go to the doctor.
>
> They can tell their pain about their sickness if they want to. They tell, they say that they cannot face the pain very much. It is too much also. But they have to go through that, the pain. They go to the doctor. They [children] take [them] sometimes. Sometimes they don't. This depends upon how good relations they have.

> If they are feeling too much [pain, they will see a doctor]. But doctor is going to say the same thing, "Talk it out what you have inside. [That] will make you feel better."
>
> I find even my sister-in-law who is depressed does not accept she is depressed. So that's one problem with depression. Until you know, it's nothing. The other reason they don't admit. It's a stigma again. They see you are depressed, they think it a mental disorder and therefore its not be admitted to. Because then people will say you are a crazy person. So you don't admit that you are depressed. To go to a psychiatrist it's just a stigma. I think for our age group it must be hard.
>
> Our Indian people will go 99 percent of the time [at] the last moment. I mean, up to 99 percent they won't go because that's the way they are brought up in India. Everything we say depression and "Hush, hush, hush," nobody will talk. Or nobody will do anything about this (a big laugh). Nobody! But I don't think there is much depression in India like here. Here, every little thing we have depression. There we deal with things and we overcome with that. But here for every little thing we go and see the doctor.
>
> I feel sorry for our women. I tell them to go and get some help or tell the doctor. I tell them no need to be like that in this country where there are resources. Here we can get help if you need. Physical or money wise or whatever resources, they can get help. So we should use it.

Besides the consequences of mental distress for life span and health care utilization, there was also mention of somatization of emotional health problems. Participants spontaneously interpreted this distress behavior as cultural expression. Several participants seemed to believe that EII women use this form of expression when they don't want to disclose their mental pain. Wanita commented:

> Yaa, they tell, they tell. Because this thing they can tell, "I got headache, I got that one." They tell [that] they have pain and they take pain killer. Or they will say, "I have taken pain killer. I have a bad headache, like a bad pain." They can tell everything about body pain.

The description of mental pain through somatization does not support Kleinmann's (1980) contention that, because of their limited understanding of the illness, many non-western people somatize their emotional problems. Instead, the participants in this study believed that elderly EIIW use cultural expressions of mental distress consciously (Davar, 1999) and not out of ignorance. Many believe that it is a strategy that elderly EIIW adopt to indicate that they have health problems requiring medical intervention, and more importantly, increased attention from family members and friends. In sum,

participants perceive that mental distress increases the probability of physical pain, disability and disease among elderly EIIW and shortens their life span.

B. Mental Distress May Affect Social Health

Mental distress also has the potential to affect social health (Brown, 1996; Isaac & Prothrow-Stith, 1997; Butler et al., 1998). In this case, social health primarily means normal social activities such as visiting friends, holding a job and social networking. Events described frequently by the participants include difficulty in performing daily work and maintaining a social network, and increased violence. About two-thirds of the elderly participants believe that mental distress reduces the ability to maintain a healthy social life, especially among elderly widows and individuals who are limited by their mode of transportation.

While a few participants mentioned violence and increased risk of verbal assault, most mentioned social alienation and isolation as common behavioral sequelae of mental strain among elderly EIIW. Vinita said:

> You know, depressed people never say. They always keep [to] themselves, even they act. From their actions, they act like they do not care about themselves. Getting up in the morning, have a bath and get ready or something. You know something is obviously wrong. When you want to go out they don't [want] to go out. This type of thing, they just sit at home. They don't want to do anything. When somebody talk[s] they sit quietly.

The above narratives clearly suggest that mental distress has the potential to affect elderly EIIW's social health. However, unlike other elderly women (Stenchever, 1996; Hayslip et al., 1997; Isaac & Prothrow-Stith, 1997; Louie, 1998; Falsetti & Ballenger, 1998), EIIW commonly experience the social health impact of mental distress in the area of social activities (Ellickson, 1988; Chakroborty, 1990; Sandhya, 1994; Davar, 1999). Many participants see mental distress not only as a potential barrier for many elderly EIIW to achieving a healthy social life, but also as a factor in elevated risk for suicide. The relationship between mental distress and loss of life is elaborated below.

C. Mental Distress May Affect Mental Health

Although psychological research has shown a strong association between mental distress and severe mental disorder (Bohnstedt et al., 1994; Baer, 1996; Ananthanarayan,

1996; Antai-Ontong, 1997; Aroian & Norris, 2000), and suicide (Bernardez, 1984; Butler et al., 1998; Cockerham., 2000), all participants acknowledged that feeling worthy is the most important psychological attribute a person should have for positive mental health. If a person feels worthless, stated all participants, the consequences will be anxiety, grief, loneliness, depression and distress. Sita explained how feelings of worthlessness can decrease a person's positive experiences in life:

> Because this worthlessness, worthiness is the most important thing a person should have. If you think that I am [she is] a worthless person, she will not see anything positive in her life. These are consequences of worthlessness.

Some participants predicted that the ultimate impact of mental distress is the "the total loss of life." Neeta explained:

> But those are the emotions they will experience: loneliness, depression and distress. With distress it will lead to dejection and finally you give up. You don't care whether you live or die. That's the giving up, you see. There is the potential for all these things to happen.

Dejection may lead to a state of chronic depression. This link between distress and depression is noted in Sumita's comment:

> I think most of them are related. They have something to do with each other. Like anxiety, grief, depression, loneliness. Yaa! They all have some connection, not always. But most of the time they are connected. One thing leads to the other. If you don't deal with one, it goes to the next. Like grief can lead to depression. If you don't deal with it you keep on thinking, "I lost this person. I don't want anymore, anything in life." And so you get depressed, obviously. That's it, you just keep crying or you don't talk, you just shut yourself off completely. That's the kind of depression which is permanent.

Amita also saw depression as the consequence of mental distress, when a person feels helpless:

> To me depression would mean not wanting to go on with your life. I think we feel depressed when we think this: "Well we are at the end of the rope. Nothing can be done about it."

Jeeta summarized the consequence of mental distress on the person as a whole:

> Loneliness will bring depression. Anxiety also can bring depression. Loneliness, I don't know whether [it] will bring anxiety or not. But loneliness can bring depression. And anxiety can bring depression.

> Anxiety will lead to depression because you are physically exhausted, mentally exhausted. The exhaustion can bring depression.

Finally, Babita explained how mental distress and its symptoms, if not managed or prevented sensitively, can lead to loss of life:

> Distress, depression I know. Of course, loneliness [is] part of this. They are all related. [They all] bounce back and forth. Depression and loneliness are related, right? Then other one is, then they suicide. That's where distress comes. Maybe I am wrong. You need couple of combinations to have suicide, right? Anti-social. Then you think more about destroying yourself, you know. I don't know! I don't have friends who talk like that. Combination can make you go for suicide because they don't have any bright [out]look. They always look down upon themselves.

All participants recognized that loneliness, anxiety, grief, feeling of worthlessness, depression and distress directly or indirectly affects mental health. Interestingly, Mita mentioned that these negative feelings and experiences are basically one problem:

> They are [the] same: depression, distress, anxiety, loneliness, grief and worthlessness. See, depression, stress, again lonely, anxiety, they are all the same. I cannot connect. I feel they are all the same. They all have the same answer. I tell god, "Bhagwan, why are you thinking that if you are hiding that you are different?" Dharma aaki hi hai [religion is one]. Dharam is one. God is also one. She says "I believe in Krishna bhagwan [god]." I believe in Kareem Aga Khan. But when you go there, god is 'one'." That is how these [mental distress and its symptoms] are also one.

IV. Summary

In concluding this discussion of the perceived meaning of mental distress and its symptoms among elderly EIIW, it may be said that mental distress is defined around two concepts: negative thinking and event-oriented problems. The participants believe that distress can affect an individual's emotional, mental and physical self. The events that have the potential to heighten the negative thinking in elderly EIIW can be appropriately placed into three broad areas: cultural difficulties, personal issues, and health related issues. Within these three broad categories, intrafamilial relationships and unprepared events such as widowhood, disability and caregiving were perceived as the major causes of mental strain among elderly EIIW living in Canada. Finally, the participants believed that if these psychological problems are not controlled or prevented, they will affect a

person's physical, social and mental health. In fact, the participants stated that mental distress may reduce an individual's life span or lead to chronic depression. The various causes and devastating consequences of mental distress in old age have added concern for elderly EIIW, even if at the present time they see themselves primarily as "healthy" individuals.

The last objective of this study is to understand how mental distress is managed by EIIW– their coping strategies. Chapter Six details the ways by which elderly EIIW maximize their "internal self" to protect themselves within a high risk, aging society.

CHAPTER SIX

COPING STRATEGIES OF MENTAL DISTRESS: TRADITION AND SPIRITUALITY FOR "A FULL LIFE"

> Anxiety, loneliness, worthlessness, grief, depression and distress anybody can have in their daily life. We are human beings, so it is a natural thing. But how you deal with them? That's the different thing for everybody -- small or big, rich or poor, educated or not educated, any caste or religion, anybody. But how do we deal with that thing that is affecting different people in different ways? How they deal with or cope with that, how they manage, is the key issue. (Sita)

The previous chapter examined the participants' construction of the meaning of mental distress. The elderly EIIW unanimously began their initial interviews by stating that they do not suffer from mental distress. As the conversation progressed, the participants gave many examples from their past and present to show the causes, types and temporal character of psychological problems. Unlike those in previous South Asian psychological distress studies (Kakar, 1982; Krause, 1989; Fenton & Sadiq-Sangster, 1996; Shirali, 1998; Helman, 2000), the participants did not explain mental distress and its symptoms in somatic terms. Instead they mostly used words such as "worried," "sad," "angry," "stressed," "depressed" and "unhappy" to explain the negative psychological reactions. In addition, in comparing their emotional experiences with those of their community friends in Canada, the participants engaged in "strong" identity construction (Schreiber et al., 1998, 2000; Kahn, 1998; Davar, 1999; Lamb, 2000).

A strong or healthy identity permits a person consciously to sustain separateness from the "feeble and unreasonable" (Foucault, 1965), "social deviants" (Fernando, 1995), those with "spoiled identity" (Goffman, 1963), and individuals who have become victims of pathological problems (Shirali, 1998; Jamal, 1998). Furthermore, the participants admitted that negative psychological problems are a normal part of human life and that it is healthy to have some level of stress. However, they believed that the difference between people arises based on how they cope with mental distress and its symptoms. This concept of "difference" (Isajiw, 1999; Davar, 1999; Granville, 2000) allowed the participants to construct a healthy identity. Through their narratives the participants showed how, despite many challenges in life, they haven't lost control over their inner

self, one of the key resources for prevention of mental distress (Lazarus, 1980; Estroff et al., 1991; Hayslipe al., 1997; Gutmann, 1997). Hence, this chapter focuses on understanding the actual management process of mental distress among elderly EIIW.

In the context of the management of the mental distress, participants seem to think in terms of acknowledging a negative event, then achieving a sense of control over it (Pert, 1997). In this study, management loosely means maximizing control over one's inner self, a conscious strategy for maintaining positive health (Weiss et al., 2003), and respect and dignity in old age (Tilak, 1989; Chakravarthi, 1995; Gurumurthy, 1998). In addition, the participants' beliefs and behaviors have integrated selected social practices (both Indian and Canadian) with original Indian traditional and spiritual ideologies to enhance their quality of life and sense of self-worth in old age. Finally, the consequences of maximizing control over the inner self have resulted in the participants' viewing culture as "medicine" for the prevention of illness and disability. The participants' risk management practice is discussed below.

The focus of this chapter is on understanding what types of coping practices the participants used in order to maximize a sense of control over their inner self and to avoid mental distress, which the participants viewed as the last stage of psychological problems, one that usually brings permanent disability or death.

I. The Indian-Canadian Way of Coping with the Threat of Mental Distress in Later Years of Life: "Maximize Control over Inner Self"

In terms of coping skills and practices to handle life's stresses, ethnic elderly immigrants have primarily depended on family, social networks, culture and institutions such as religion (Boneham, 1989; Dossa, 1994; Blakemore & Boneham, 1994; Ujimoto, 1994; Plummer & Slane, 1996; Zhan, 1998; Quadagno, 1999). Such comprehensive coping resources generally are described as *buffer agents* (Novak & Campbell, 2001). Earlier coping research and psycho-cultural gerontological studies described an individual's defense mechanisms as generally unconscious (Lazarus, 1980; Taylor et al., 2000). In this study, it seems that the personal and social actions employed by the participants are conscious processes and a learned construct (Charmez, 1990; Meleis & Hattar-Pollar, 1995; Davar, 1999). All participants reported that, to "maximize control

over one's inner self," it is necessary to remain busy.

A. The Coping Psychology of Elderly East Indian Immigrant Women: "Staying Busy"

> My son's daughter [comes to me]. I have to cook and then I sleep for a short time, because I go at 4 o'clock to the Jamat Khana. Everyday I go from 4 to 6 o'clock in the morning. Then I return. Everyday in the evening it is from 7:30 to 8:30 pm, for anybody who is interested. Men and ladies all go. My husband works now, so he doesn't go in the morning. He says when his work finishes in March then he will go. He will retire in March, then he will give me ride [to the Jamat Khana]. He will come with me. In the evening at 7:00 I am ready, my husband comes from work and then we go at 7:30 and return at 8:30, that also daily, Saturday, Sunday and Monday. He returns from work, we drink little bit of tea and then we go. We return at 8:30 and then we eat. So you see how *busy* we are. You see how I am *busy, busy*. My granddaughter comes at 9:00 am and she leaves at 2:00 pm. Her mommy works in McDonald. She comes to pick her up, she goes. Then I do little bit of work. And at 2:00 my husband leaves for work. When he leaves then I have little snacks, then if I have to cook, I cook. If I have to take shower, I do. I do all my work. Then I take a little nap. I sleep for few hours. I wake up, then it is time for evening snack. When he arrives at 7:00 pm, [we] go to our church. (Mita)

The discussion about maximizing control over one's inner self revolved around the social-psychology of "staying busy," which Butler et al (1998) calls, "working off the blues" with daily tasks. In this study, the participants' typical talk about staying busy falls within the Indian woman's life course perspective (Lamb, 2000) and belief about "the act of duty" (Mays, 1983; Pillai, 1985; Gurumurthy, 1998; Davar, 1999). Staying busy includes five basic activities: (a) engagement in family or household affairs (grhasta)[74], (b) performance of religious duties (dharma), (c) acceptance of fate and action (karma), (d) establishment of a financial support system (artha), and (e) living independently (sannyasin) to prevent, offset or minimize mental distress. These social-moral duties have also incorporated the knowledge of the group's social history (Buchignani & Indra, 1985; Dossa, 1994; True, 1995; Shirali, 1998; Lamb, 2000) to enhance their inner strength.

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[74] The five terminologies are taken from the life model of Brahmanical theory (for detailed analysis, see Dumont, 1980; Tilak, 1989; Chakravarthi, 1995). The words are Sanskrit translation. According to typical Indian precepts, epistemological, emotional and ethical developments in the human being occur during the entire life span. Scholars argue that if this humanistic psychology is followed appropriately, it provides a strong sense of selfhood in family, society and culture, positive health, and a happy, full life in old age. In this study each category shows the type of activities that individuals perform to achieve the objective (i.e. prevent mental distress) and maintain their healthy identity.

Figure 8 provides a diagrammatic representation of how control over the inner self is achieved and maximized.

This model has five parts, unlike the four linear and traditional Indian normative life stages duties (i.e. studenthood, householder, forest-dweller and renouncer) (Chakravarthi, 1995). These parts focus on ways of living rather than age-specific activities. The circular nature of the model illustrates that this ideology can be transplanted and practiced within each life stage, and in any social, political and geographic environment. The participants emphasized that all these activities are necessary and continuous; none is sufficient in itself for ultimate health status, general wellbeing and quality of life. Within this model, the first measure of coping with emotional problems reflects the participants' sense of control over their social behavior; the second, third and fourth risk management techniques are cognitive measures; and the last strategy mirrors their lifestyle acculturation under pressure.

The five activities in the outer layer of the circular model exemplify the perceived distress management forces, give the the participants a positive sense of self worth and help to maximize internal strength. A feeling of self worth is often associated with power and control (Butler et al., 1998) to restructure an individual or group's status in the societal hierarchy. The participants believed that one can achieve self worth and also maximize inner strength through the positive feelings resulting from engagement in everyday activities. They indicated that this inner strength has helped them to avoid mental distress and not require western medical intervention. In the following interview excerpts, items dealing with the management process of negative psychological reactions are italicized. First, Sita's comment illustrates how engagement in social-moral duties provides a sense of self worth and happiness, the two major psychological resources for maintaining a strong inner self:

> Because we believe in god and god has created and sent us to this world. We had to live with a positive thinking. I have a purpose in living, so in order to carry out that living I have to live with that, that is the major thing. We have to live in this world, and we have to lead a family, and we have to be an example to our children and all those around us. And *if we find happiness in ourselves, then only we can give happiness to others too*; to children, to friends who are in need of all that.

While Sita's discussion focused on having a purpose in life as one way to prevent distress, Geeta explained her pro-active approach to exert control over her inner self:

> So you try to face the problems before they almost happen or take on their own little identity in our lives. So we try to combat before anything happens rather than after it happens.

Sunita provided an experiential answer to the question of how to encounter the life's challenges and live happily:

> *If you don't face [life challenges] you die miserable, not happy. If you are happy, you will survive. I made myself miserable lots of time.* Then I thought of my grandmother's preaching that "[If] you want to live, you have to. Those things [problems], they come and go. But it's your duty not to make your sorrow so unhappy."

The remainder of this chapter describes in greater detail each coping practice for mental distress. In the interviews every participant except one expressed that at the present time she is personally too busy to feel or experience mental distress or disability. Based on this theme, the analysis focuses on how EIIW keep busy.

B. The Types of Coping Activities of Elderly East Immigrant Women

> You know, "Hai, hai something is happening to me. I am suffering. This is happening to me." So what? Try and get out of it. Don't sit there and expect someone to pull you out. Then you don't feel [bad] because your energies are concentrated on a positive activity. Then you don't feel the anxiety and the worry and the dejection and the stress and all these negative emotions. (Geeta)

Figure 8. Elderly EIIW Coping Paradigm of "Staying Busy".

Engagement in Household Affairs (grahasta)

As in previous empirical research (Vaux, 1985; Gallagher, 1987; Driedger & Chappell, 1987; Boneham, 1989; Climo, 1990; Shenk, 1990; Guha, 1992; Quadagno, 1999), the common approach identified by the participants for dealing with emotional disability is staying engaged in household affairs (*grahasta*). For these women, involvement in family activities means exchanges of help across generations. To the participants, household deeds evolve around Indian aged role model theory. According to this theory elders are viewed as active, experienced and knowledgeable agents – the "ultimate master of the earning of the family" (Desai, 1985, p. 205).

Based on this ideology, the participants stated that commitment to and engagement in everyday household matters have so far given elders a higher level of

social status, position, respect, honor, and most of all internal strength to transform any negative situations so that they do not feel worthless or lonely. Instead, they have full and happy aging years and are prepared to experience disability and death without mental distress. Amita's discussion corroborates this view:

> I know my mother, my aunt, they feel very worthwhile because they are participating in the family. Just like me. Their opinion is valued. They are very important for their grandchildren. They are kind of "golden girls" in our family, because they do cooking, sewing, and tell stories to the younger children. Very reliable babysitters and take care of the sick. They listen to the kids, whatever is going on in their school. They are valued, worthwhile, and really valued. So I would say they are a great asset as a group. They give us religious foundation, what's right or wrong. They provide a solidifier for the family. And they are great conciliators. Ours is not an ideal family, [but] our elders are great connectors and unifiers. So instead of deriving out of them that they are lonely, maybe they are realizing their self-worth with their own effort by counting their blessings. Yaa! Because life is how you look at it. It's all about attitude.

Similarly, Kunita described how her position and active involvement in the household chores have given her a reduced level of emotional strain and a high level of personal satisfaction in Canada. She stated some of her accomplishments, from handling financial stress to dealing with her mother-in-law:

> I didn't have too much money. I managed very well. I don't want steak, I cook stew. [If] Mohan [my son] want[s] something else, I make it. My mother-in-law want[s] something else. Four kinds of cooking meal I did, working eight hours. You know, that is not a problem. I like children [to] eat well, sleep well and read well. I get up at 4 o'clock and take bath and pray first, pray one and half hours. Then come to the kitchen [and] make something; my mother-in-law want breakfast. Sometimes I fry potato juanrj in butter oil. Sometimes I make cream of wheat, porridge. Different things so that she get up and eat. She eat breakfast and lunch together. I make her meal. She knows how to [turn] on, put in microwave, and she warm it up and eat. Whatever I make she eat, and she eat well.

These examples show the life struggles these women have encountered in Canada, and also the complex role immigrant women play in the success of their families and in the maintenance of healthy identity. In this context, a healthy identity includes the physical, mental and social abilities to perform multiple tasks. All participants were well aware that most of them had immigrated to Canada under the family class category in

order to gain a better future for themselves, their children and grandchildren. As an "ethnic, sex and age-class," they continued to believe that they have sociopsycho-moral contracts: they see their role primarily as "manager of family," including the joint and extended family system. While most participants see themselves holding this management position, several felt that because of this social responsibility they hadn't succumbed to mental distress. Instead, awareness of their objective in immigrating to Canada has helped them to convert their negative experience to positive experience, and led to increased inner strength to encounter the challenges of old age.

The participants' authority, position and status labels within the family context were variable, ranging from wife, mother, grandmother, aunt, daughter-in-law, sister-in-law, to mother-in-law. These social identities or "multiple selves" make for a strong sense of caretaker status between mothers and children across the generations, within the family and community (Finch & Mason, 1990; Walker, 1992; Gutmann, 1997). Similarly, to feel meaningful and worthy, to maintain authority, and to prevent mental distress in later life, the participants' daily household activities included three major tasks: maternal domestic chores, financial advice, and cultural guidance.

***Maternal Domestic Chores*:** Grandparenting was at the core of the maternal domestic chores and distress management tasks of elderly EIIW. As in many previous studies, grandparenting was characterized by the elders as a strategy against loneliness, grief and depression (Holmes & Holmes, 1995; John et al., 1997; Guglani et al., 2000), a symbol of attachment, and a way of maintaining family ties (Climo, 1990; Gutmann, 1997). Several participants also thought that because of their grand-maternal duties, their old age has been meaningful and worthwhile. Following are five grand-maternal characteristics that have helped prevent psychological problems and maintain the role, respect and authority among the population under study.

i. *Grandmother as caregiver.* This coping resource was frequently mentioned by all participants. They believed that to gain respect and love from others and to minimize the risk of mental distress, one has first to perform her duty well. Many explained that caregiving, the key female duty (Walker, 1992; Arber & Ginn, 1995; McDaniel, 2002), not only keeps an elderly woman engaged for the most part but also maintains her

dignity, with no feelings of loneliness or mental strain. The following excerpts describe the role of grandmother as caregiver and its importance in alleviating the risk of distress among this group. Vinita explains:

> See, some people, our ladies help their grandchildren. Some ladies help their daughters. Me, I help my daughter. Sometimes when she wants to go somewhere she will phone: "Mom, I want to bring my kids." My husband help[s] me too. So that is how they spend their time. I have five grandchildren. The last one is only five months [old].

Wanita worries about her family members when she would be away.

> I am leaving for India, next month. I worry about [them] because they need us sometimes, you know. They need us to look after grandchildren. I am just worried about that. When I [am gone] going, what is going to happen?

Wanita further elaborated her attachment with grandchildren. In so doing, she showed how important this grandmother and grandchildren interaction was to prevent any psychological strain on both:

> My grandson [says], "Aji [grandmother], come to my place, because today is Friday and I don't have school tomorrow. Stay with me; have a sleepover. Because the kids are staying with the parents. Before, they [Indian grandchildren] live joint family. They prefer to stay with grandparents. The kids get attachment. [In the nuclear household] they feel nobody is there, they see the face of mom and dad in the morning and evening, only the daycare. So [there is] not [no] attachment for the kids here. Kids' life is tough here too.

ii. *Grandmother as Babysitter.* Babysitting is another way for these women to remain engaged and reduce the risk of loneliness, worthlessness, depression and mental distress. A few participants said that they were regularly babysitting their grandchildren as part of their daily household activities. Several said they were helping their adult daughters, and two their adult sons, in babysitting, the social reality of Indian maternal culture (Gangrade, 1988; Davar, 1999). Mita reflects this expected grandparenting responsibility and obligation when asked if she works outside the home:

> No, I didn't [don't] work. I stay at home and my husband said, "You stay home and babysit our granddaughter. Otherwise our son will leave her with somebody else and he has to pay money. What good is it? You are his mother and so you do babysitting."

Like Mita, Kabita provides childcare and also teaches Hindi (the Indian national language) to her daughter's children[75] in order to remain engaged and reduce psychological strain:

> I like to do something. Always I do something. Sometimes I used to do knitting or embroidery. You have to have some hobbies, also to get rid of loneliness. That's the thing. I always think, with grandchildren, they are pretty jolly persons. So I teach them Hindi and they go to Hindi school. They know Marahti, but they don't speak. But they like it.

It appears from the women's talk that babysitting not only assists them in removing loneliness and maintaining their social worth but expresses their commitment and contribution to joint-family well-being. Most described this type of unidirectional giving as essential for their family's upward social mobility (success) and their personal mental well-being.

iii. *Food Preparation*. The psychological distress management theme of "household affairs" includes chores such as cooking, particularly traditional ethnic food, and feeding people. This nurturer characteristic represents Asian mothers' "love," "power" and "control" in household matters, regardless of their age, education and cultural differences (Lee et al., 1995; Mehta et al., 1995; Gurumurthy, 1998; Ingersoll-Dayton & Saengtienchai, 1999). It also legitimizes their status as "healthy" and "productive" members of the family and of society, which has traditionally devalued, marginalized and disempowered unproductive individuals, particularly women who are victims of physical and mental disability (Kakar, 1982; Chakraborty, 1990; Davar, 1999) or depression (Shirali, 1998;).

In this study, although a few participants claimed to be "good cooks," daily cooking was more frequently mentioned by women who saw themselves as fulltime homemakers and those who follow a traditional Indian diet. Acculturation in food habits is rapidly taking place among the younger EII generation. Therefore, involvement in preparation of certain kinds of food gave the participants status in the family as a

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[75] In traditional Indian ideology parents primarily live and support son(s) and their family. This is the main symbol of Indian family identity. Evidence of sociocultural change in gender of the child appears in the caregiving discourse of the elderly participants. In so doing, they have made their traditional role more complex. This change has contributed to the maintenance of a strong Indian family identity, as opposed to disintegration of family in postmodern Canadian society.

productive member, an expert cook and maintainer of tradition. It also brought less strain as a result of disengagement from household activities. Sabita describes this "active" aged Indian maternal characteristic:

> Nobody's love [is] like mother love. Yaa, my children also say! My son, whenever he comes, always [I ask], "What [do] you want to eat?" He eat[s everything], this one, that one. He said, "Oh, mommy, you are making so good." Doing like that (massaging his stomach – a big laugh). His wife also [says], "Your mother is [a] very good cook." (another laugh) Yaa! Nothing like mother.

Sita gave a second example of active elderly Indian female/maternal identity:

> We are more responsible for the family, you know. That could be the reason [why I feel worthy]. Even my daughter, they eat outside most of the time because they like pizza or they like hamburger. Although they eat or not, I will always prepare for them, you know. Sometimes they change their mind and say, "Amaa, I am staying home and eating." There is plenty of food for them. So I think I am worth for them, you know. I think I am worth more for them. Yaa, that's what I think. Anytime anybody come, even if you want I can give a large supper. I have everything, you know. I never cook for just two.

iv. *Housekeeping in Later Life.* In keeping with the theory of housekeeping and love (Devadoss, 1979), Babita also spoke positively of her role as an elderly housekeeper. She feels that amidst all the domestic demands, she and her husband are having a happy retired life:

> I try to make [keep] as busy as possible, then I get a good night sleep. If I don't do it, then I find it very hard in the evening and the night too. If I don't do anything, you know, I try to. But I am not [a person who likes] greatly being [or] sit lonely for a while, you know. That is one of my healthy ways of relaxing myself. I have boys here. Kids [grandsons] are only four and six. My daughters, they stay here. As soon as they come here, there is no loneliness in this house. I cook for them. And sometimes they are here, sometimes not. But I am always concern[ed]. So they keep me busy. One guy is four. [He] is going to kindergarten so he is here at 2 o'clock. He climbs all over the places. I have to be watching him all the time. Other day, he fell from the counter and he got two big bumps here. He is okay. But if I touch it, he says, "Amaji it's auie. Don't touch." The six year-old is naughty but not naughty, you know.

Amita commented on her maternal housekeeper role:

> I have been a teacher for thirty years. I do have an older sister who lives in India, but here I am the eldest one, and I have been a kind of great nurturer

> to my family. All my family members are here, and I am very grateful to them that they have not betrayed me. I am still part and parcel of their major living. I have only one son who by the grace of god is doing well on his own. He is married. He has two little girls. They are very bright girls. I hope all grandparents get the same kind of fulfillment from their grandchildren. Although I see them only once or twice a year, I still feel very grateful [that] they are being looked after well by their other grandmother, their mother's mother, because that lady also has only one daughter and she is taking care of my son, my two grandchildren and her own son. I feel very comforted to give my son to her. I tell her, "For forty years I looked after him. Now you be his mother." I love my son but feel very good that I don't have to worry about putting him on the right track. Not that he needs it. I know, even if he doesn't need it, I feel it's like part of my elixir of my life to watch him and give the advice. So his mother-in-law does that and I feel very, very relieved. Because bringing up children, it's fulfilling experience, but it's also full of many, what should I say, very bumpy road, you know.

Sita emphasized the important role she holds in housekeeping:

> I have to do all my responsibilities as a mother, as a wife, as a sister or friend. So whenever I do, I have to carry out all my household duties, all the duties of my husband and children. I had to bring them up in the proper way. All these come under the responsibility as a mother and a wife. So then only they will succeed in the world. Otherwise you will fall apart.

v. *Maintaining Healthy Relationships*. Sita emphasized the powerful hold of old traditions, theological sinews, ideological foundations and social customs in providing positive energy in order to encounter negative events without losing self worth:

> According to our culture, our mothers give the positive ideas. If we have some problems with anybody like children, [or] when we had problem with our friends, they used to give us the positive ideas like "Don't do [take] any revenge." Be patient and forgive, like that. All these make up your character.

In the context of maintaining healthy relationships within the family, Kabita mentioned advice she received from her deceased in-laws and still follows. She also discussed how she evaluates her own attitude and actions to minimize her emotional depression and prevent future suffering:

> Sometimes I do [feel depressed]. My in-laws humko bataya ki kya karna hai [my in-laws told me what to do about it] – wua batai ke bhajan soon, kuch atma parikhayan apne ap karo, ki kya ap kaise ho [they told me listen to religious songs, do prayer and evaluate how you are doing]. See how

you are and what you have done all day and how you can improve yourself. There are so many drawbacks in myself, so I should see from the very beginning what all day I have done, and what things wrong I have done. How I should try to avoid those things which I shouldn't have done. That is why I should improve myself that way. Or sometimes if I complain about somebody, "Shayma [my daughter] your sister-in-law, my bahu ne aisa kaha diya" [daughter-in-law said such a thing]. Usne aisa kahe diya, tumhare bahu; aisa aik dusri ki chugli nahi karma chaia? Ye karne se hamare loksan ho gaya hai [my daughter said to me, "Don't talk behind her like that]. Ye karne se hamare loksan ho gaya hai. To humne agle bar aise apne bahu ke bare kharab apani bait ko nahi batana hai [I thought that, by talking like that, I put myself at a disadvantage. Next time, I never said anything to my daughter about my daughter-in-law]Un me ladhai ho jait hai na? [they fight among themselves, you know]. Aisa nahi karna, aikbar jadi kia ursa aisa hi hua tub aisa nahi karna. This is the way I should improve myself. What wrong I have done? You observe and improve your behavior.

Finally, based on personal experience and knowledge, Neeta reemphasized the internal strength EIIW have to manipulate negative family situations in order to avoid confrontation and prevent mental distress. She compares this behavior to that of Canadian-born women:

> If she [EIIW] is tactful enough, she could bring about the change in him [her husband] rather than making it a confrontation from day one. If she is tactful (a big laugh). Most women are tactful, and they are not looking for confrontation. Our Indian women are a whole lot better than local women. I don't know what you think of them. They don't even have any identity, local women. Yes, they [EIIW] do. For all outward appearances they might look submissive [but] they are not. They get their way. They tactfully get their way within a family environment. This is what their training is all about, I guess generations of training. Culturally they are different. They are not submissive.

In summary, the participants believe it is critical to practice multiple maternal nurturer roles to ameliorate mental distress and its symptoms. According to their experience, being involved in domestic activities yields feelings of satisfaction and worth. Most of all, the elders expressed that, through their traditional physical contribution to the family and their acceptance of familial shortcomings, they continue to hold a respectable social position in the family and do not suffer from severe mental distress.

Financial Guidance: While discussing household chores, several participants mentioned financial guidance and support of family and adult children as another activity that contributes to self worth. It gives a sense of status and control to elders in the Indian immigrant household and adds a dimension to their strong inner self. This parenting role is well-founded all over India among older men (Nayar, 1994; Willigen et al., 1996; Yadava et al., 1997). It has now somewhat extended and changed the caregiver and nurturer image of aged EIW (Desai, 1988; Dandekar, 1996; Gurumurthy, 1998). In addition to their traditional nurturer role, the financial support that some elderly women provide to their adult children was described as a critical indicator of their privileged position as elders in the Indian family structure. Few participants described themselves as the financial "caretaker" of the family. Nevertheless, Sumita comments on the difference financial power makes in having a strong inner self:

> It is people whose cognitive sense is in good condition. They feel distress when they are physically, financially not able to do anything. Finance can help. If you are rich and still old and not help, it still helps, it gives a sense that you are worth. Because you can help financially the people, you have some kind of contribution to make. It's not control. I mean, if you are a big millionaire or something, I suppose you will have control.

Babita described how she provides financial assistance to her children and believes that this guidance is another part of her duty. In so doing, she thinks that she is not only performing her important cultural function but also maintaining her self worth and "active homemaker" status in the family:

> I provide money for them [children]. Cooking is not the only thing, but it is part of the housework. I do that; that is why I am not lonely too.

These descriptions of the leadership role or status within the family context show that, in addition to the "homemaker" identity, several EIIW find a strong inner self with the "financial caretaker" identity. This identity seems to contribute to their sense of success in life and retirement and to a strong inner self in old age. Sunita elaborated on this coping strategy, using her life story as an example. Although her parents have long since passed on, she remembers how her father gave her financial support not only to reduce her financial distress but also to enjoy his role/status of "productive parenthood" (Gutmann, 1997), another symbol of self worth:

> Thinking of my family, as my husband is very dominating, he wouldn't like me to go and talk to anybody. He [has] forbidden me talking to anybody. [He] wasn't giving that much money in the house, just [enough] to run my household and cook food. But my father used to say, "Still I am alive and if you are not married, I could have looked after you. So just think that way and have some money from me and don't deprive your children from food. Even clothes are not that necessary as food. So feed them well and good food. Whatever you feel like and whatever they ask, you give them and take money from me." I wanted to work. He said "No! Your first duty is to look after your children and look after your husband, and don't worry about money." Every time I went he gave some lump-sum money, to keep it and from time to time spend whenever it is needed.

Cultural Guidance: In addition to physical and financial contributions to the family, participants believed that assuming a cultural broker status assists in minimizing or offsetting any life-cycle crisis. However, unlike the elderly women in India who have an active role in folk medicine and assistance at the time of childbirth (Gurumurthy, 1998, p. 132), the elderly EIIW seemed to have an active role in the continuation of tradition, culture and faith teaching in the diaspora (Guglani et al., 2000). In order to enjoy good family relationships, remove uncertainty, retain their traditions for future generations, and gain a sense of satisfaction in later life, the participants valued involvement in a range of activities devoted to retention of culture and tradition. Some reported performing activities within the household, such as telling young grandchildren stories about their childhood, mother and grandmother, stories with a moral theme. Others seemed to be involved in the ethnic and religious activities of their community. For example, Kabita's husband and daughter give religion lessons in English in the temple:

> You see, what happens when the priest gives lecture, it is hard for the little ones. They don't understand Hindi and he [the priest] speaks Hindi. So they start running here and there. So my daughter and my husband take them [children] downstairs of the temple to teach them some hymns and slokas and telling them some religious stories. So in that group, sometimes I go there.

Similarly, Sita mentioned:

> [Because] we are here, we could do that [build a church]. And we have a church here, so we could contribute towards the church. [This is] because of our cooperation and few people from the community. Because we need a church for worship, not only for our generation but for next generation.

> Our children are here, so they need a church too. Without going to a church we don't get the moral principle to live in this world. Anywhere, in India or in Canada or any part of the world. [In our Marthoma church] we pray directly to god. But since we are from Marthoma family, I like to have my son also follow the same tradition. And even though there are various churches, we wanted our Marthoma church.

Mita, who goes to Jamat Khana regularly, provides a further example of cultural contribution arising from staying busy in housework:

> When I [was] small I saw my mommy and daddy going to the Jamat Khana. So I did that, and because I go all the time my children will go. So this is how it continues. My son says, "If I don't go one day, I don't feel good." I said, "Jamat Khana is a very good thing. Go and visit. You go for film, you have gathering, invite your friends and eat and drink with your friends. Sure you have to do that. But also do this little bit, go to Jamat Khana, make time for it." They tell me they are doing [that] and I am happy.

Other popular cultural/personal activities emerged from the data: traveling, volunteer work, community cultural activities, walking,[76] swimming, and teaching or singing traditional music. Some saw these various activities as ways to remain socially active; others described the duty to deliver traditional services in a social environment where they were otherwise unavailable. The participants believed that their continuing sociocultural engagements have helped them not only to deal with isolation issues but also to maintain dignity and build a strong inner self. The following excerpts reflect their involvement in cultural activities:

> I am a Sai devotee [referring to Satya Sai Baba who, according to his disciple, is believed to be the incarnation of Hindu god Vishnu]. I go to Sai Centre. I am a member [there] and there we have an emergency committee – [if] somebody died, we plan, provide burial assistance and whatever the family need, we go and help like…visit and all sorts of things. (Vinita)

> When I didn't have surgery on my knee I used to do a lot of social work, doing something in the society. I was announcing programs from CKER radio. I was the announcer there. I did a lot of volunteer work and something for society also. (Neeta)

> No, I don't feel myself worthless at all, because I am doing everyday what I can do for anybody. And that's what my daughter is doing. She is not

[76] Walking primarily includes a stroll in the neighbourhood, shopping mall, ethnic market malls and walking to the doctor's office.

> married, she has no children. Even she loves everybody and she is saying all my aunties are real aunties. (Sunita)
>
> I go and play bridge, or I go and sing. There are so many different things – go and look. Sometimes we are liberal and do these things. I go and swim in the university pool, I sing, I teach [Indian] music. So I don't have feeling like crestfallen [or blue, depressed, disappointed]. (Anita)
>
> I feel sorry because she [a widow] don't [doesn't] understand anything. If she know [knew], she will [would] be more comfortable. Sometimes I go with them. If they say, "Mrs. Kumar[77], you speak better English than us, can you come and help us?" Especially [going for] to waxing like that, for hair style. So I go and explain and they explain [back to] me. Some ladies speak Hindi and Gujurati. I know Marahti little as well, not fully, like English. So I help them. I go with them. (Sabita)

Besides engagement in cultural and community activities, integration of past cultural memoirs is another explicitly mentioned mechanism used by most elderly participants to maximize control over the inner self. For example, Geeta reported that in old age it is important to integrate past and present reminiscences in order to convert negative energy (e.g. feelings of guilt or anxiety) to positive. This converted positive energy, Geeta states, enhances elderly women's self worth, helps to protect their inner self and, finally, helps them to preserve a healthy identity. To describe this healthy aged female self, Geeta offers positive stories concerning her mother and other seniors:

> Each one has to make her own philosophy. How am I going to deal with [feelings of loneliness, distress or feeling of worthlessness] in that situation? That doesn't mean you never feel despondent, don't get me wrong. That doesn't mean you never feel clouds in your life, you never feel distress. To me, I look up to individuals that have inner peace, that have conquered all the parts that personally made me very squeamish.[in] life. They are living with their children, they are dependent, they have been dependent all their lives, and still have their inner peace. When I see individuals like that, my mother, other individuals in society, I put them on a pedestal and try to emulate them, what they have achieved. Why they have achieved it. And how they are spreading the message of love, whatever, caring. So I try to emulate that. So if you worry about others, I think you have taken care of your inner peace.

Since intra-familial conflicts are common, in the traditional Indian socialization process women are encouraged to root their identities in female/maternal caring duties (Davar, 1999; Lamb, 2000) in order to manage problems and sustain self worth. Sunita

[77] All names used here are pseudonyms.

emphasized the strength of Indian "maternal thinking" by cycling back to her childhood experience and remembering her grandmother's role in the world-view of "care" (Davar, 1999):

> My father was a happy man. A happy man, happy daughter-in-law, because my grandmother used to say, "You are [both] my daughter-in-law and daughter, both you are." So she was happy. One child and she never let her do too much work, because grandmother will do it. "You look after my grandson that is your duty and my son. I can look after the rest." And she looked after us very well. Still more than [my] mother, I remember my grandmother and her preaching. She used to sleep with us and teach us all those things, and tell us story about my uncles and children. She had nine children. My father is a survivor. And she used to pray, [when] something little happen. She used to pray and kneel for my father, or anything happens to us. She looked after us very well and my father too.

The EIIW participants reported cultural contribution as another major way of remaining engaged in nurturing and community affairs. Cultural contribution, in turn, promotes self worth, eases negative feelings, and prevents mental distress.

Religious Activities and Belief in Faith and God (Dharma) Prevent Mental Distress

> You know, anytime everything happens you always say, "Oh, god help me." That's the first thing that comes to your mind. You try to put everything in front of god, you have that belief. Because [there is] some sort of religious belief in you. (Sita)

The participants pointed out that talking is another important non-clinical resource to reduce the risk of mental distress. Some described talking as a good "therapy," others as "medicine" for offsetting transient psychological problems, particularly loneliness, grief, anxiety and emotional depression. However, many admitted that they talked about mental grief not very extensively with family members, friends, religious leaders or health professionals, but primarily with "themselves" through worship, prayer and meditation. This method of coping with psychological problems is a cognitive strategy popularly known as "self talk" (Pool et al., 2001). Self talk is extensively used in sport psychology as a way of coping with tension and anxiety. Self talk was the most popular problem management strategy among participants in this study.

"Self Talk": Through their use of self talk for prevention, intervention and healing, participants also showed that spiritual guidance is important for elderly EIIW's

emotional health. Self talk enables a person to adapt to and remain in control of circumstances (Koenig et al., 1988, p. 94). It allows a person to correct bad habits, modify activation, give attention to the situation, and increase self confidence and efficacy (Koenig et al., 1989; Poole et al., 2001). In this study, these functions are illustrated through several instances of self reflection. Vinita explained how she controlled her cognitive anxiety, which she equated to anxiousness, about the uncertain future and crisis events through self talk:

> I used to have anxiety, like some type of scare, like born in one place [but] going to [another], where is going to be the end, about my children, things like that, not now. When I felt like that, I used to sit and talk about that. I think, "Why am I thinking like that?" I read a lot. I read book, got some points. I also read lot of our religious books. In our religion we have a lot of good things. When I started reading books, especially Baba's books, it helped. Reading the books, it shows that all is god's creation. And so what is the difference? My children and somebody else's children are all the same. I look [at] everybody and say people change. Before, I used to think, "I [was] born in India and I am going to end over here. Few years later nobody will even think about me" (another big laugh). Now I see everybody is here like me. After reading lots of books I began to think, "Why am I thinking like what will happen to me after my husband's death? My kids? Nobody will know who my children are after I die." Always I only think about myself, all selfish things I am thinking about. Then I said, "That is not nice, I should stop that" (an extended laugh). Now I am writing all these things I read from books, what is life, I file all these things. I will leave these things for my grandchildren. They will read when they have time. I told the oldest one, "I am writing all these things for you, for nobody is going to talk to you about these things. Whenever you get time you read, or if anybody else wants to, you can show." When I used to read them bedtime stories, they used to ask me, "Amaa, tell us stories what your grandma told you. How you grew up over there [India]."

Leeta provided another example of this ingenious approach to counteract mental and physical disturbances:

> I had so many disturbances. So I experienced both physically and mentally. In 1989 I had cancer in breast. I had surgery to take off my breast. I quit my job…[However] god gave me the most strength. I prayed, I went to the church every week [and] I read books.

Lalita mentioned that to overcome personal tragedies she and her friends not only talk but also pray:

> Traditionally we do only praying, just praying and praying will help. See, like we Christians we don't [do] this kind of that puja and this puja like Hindus and all. We don't have that, we have only pray. But puja is one kind of praying too. I know that but ours we do ourselves. Few ladies together, we sit and read the Bible and pray. Or we go to the church. That's the time, you know, we pray. You pray in your mind. That's the thing I do, nothing more.

For most participants, self talk and withholding feelings from others seemed to be a sign of control over one's cognitive self. They sincerely believe that to minimize the impact of any negative events and prevent mental distress, self talk is an important distress management approach. Bonita describes this coping approach, using meditation as an example of self talk:

> I will say anxiety is a silly thing. We create anxiety. If we [talk to ourself and ask] why? We should have faith in god. That is where religious meditation comes, you see. And we tell ourselves, "Whatever will happen, will happen. We will face at that time. Why worry, why [have] anxiety?" This is the main thing, meditation, and [at] this age we should have. That gives you strength to overcome all the grief or relief. Even loneliness, if you meditate. See, something is there, [and] it gives you company also.

Kabita also provided an example of association between age, self realization and controlled inner self. None of the Indian feminist theorists, social gerontologists or theorists on female spirituality would deny the large role self talk plays in determining women's experiences (Koenig et al., 1989; Sandhya, 1994; Davar, 1999). However, Kabita attributed her learned attitude to Indian lifecourse philosophy and aging:

> When you are young your thinking is different. When you [are] middle age your thinking [is] different and when you are old age, [which] you are not yet. But when you [are in] old age you won't do anything wrong, I tell you. Because you fully experienced your life and what you have done wrong, you realize. [And] that make you good thinking. Do something good for everybody. Nothing bad, do it good, you will get [your reward]. Bad experience, god will make you happy. Let them [be bad]. You do what you like, I do what I like. If you want to behave bad, behave. Why should I bother? What I do is up to me, isn't it?

Several other faith-related practices were reported that are axiomatic to the Canadian-Indian mental pain prevention model. They include devotion of more time to religious or spiritual activities, continuous belief in god and faith, and attendance of religious institutions. Although these activities overlap with self talk, they differ in some

ways. These faith-related practices are associated with the role of dharmic duties (i.e. adherence to tradition and practice). They are believed to enable a person to retain self worth in old age and to provide vital intrapsychic and cognitive energy to control life's disappointment or inner pain. In addition, attendance at religious institutions is a coping strategy that provides a physical space (Koenig et al., 1989; Dossa, 1994; Hooyman & Kiyak, 2002) in which elderly women may avoid loneliness, express maternal love, and compare themselves to others who are psychologically worse off.

"Devote More Time to Religious or Spiritual Activities": The participants were asked to describe how elderly EIIW deal with stressful life experiences. Their descriptions of perceived behavioral responses to negative events seemed to reflect cultural knowledge and practices, such as performing traditional spiritual duties. These duties include measures such as prayer or puja, reciting god's name, listening to religious songs (called bhajan) or music, reciting slokas, watching religious movies, fasting, and participating in a spiritual discussion group or community services. These measures are primarily chosen because they are perceived to work better than medication, especially when the health problem is perceived as not life threatening. However, for most participants, prayer and worship are an important part of their everyday lifestyle. They believe that these daily rituals give them power to cope with everyday reality and to live comfortably.

Although most participants mentioned prayer as a habit and self discipline, one said she prayed because she had seen her mother or grandmother doing it for purposes of pain relief (Sandhya, 1994; Lamb, 2000) or healing (Kakar, 1982). Similarly, Neeta said:

> They [elderly women] turn to some solace, seeking solace from wherever it comes. And the easiest thing without having to involve other people is prayer. Because again, our society and our culture ingrained into women that you just don't take your troubles outside. So you have to find all these things, the solutions, yourself. If there is a problem, you don't even discuss it with your mother for that matter [a big laugh].

Despite such interpretation, there was ample indication that for the participants, individual or collective religious practices are crucial resources for dealing with psychological pain and suffering. The following stories of recovery from life stressors or circumstances provide good examples of the role of religious practices in maximizing control over the inner self.

i. *Prayer Helps in Recovering from Life's Challenges*. According to the interviews, it is clear that faith in the power of prayer has guided several participants in their experience of pain. Most importantly, prayer or worship (as an internal resource) not only gave comfort but also helped many to recover from life-threatening challenges. The positive contribution of prayer can be observed in the stories shared by most participants. Four personal experiences are presented as examples:

> I pray. Pray[er] is the best, if you can pray, sit down quiet and think. I know, I shouldn't say, when he went [to] New York, I bought this house. A big light came, god came and he told me [he had an accident]. I cried a lot. I could not stand anything bad. He said, "Give love and god will help." And you always help. You won't be a millionaire. Children will be millionaire, [but] you won't be a millionaire. But you will have enough to live comfortably in your life. And that year, you see, everything went well. [If] I wanted $50,000 I could have it. I feed two hundred people, no problem. My things never finish. God gave me strength; I always see god in the house. (Kunita)

> We all have anxiety [about] how well they [children] will be established in life. About their career, about especially for the girls or boys, their wedding. That has to be done. So, this cause anxiety. And my husband had a heart surgery. He had a high blood pressure and after that he had a chest pain, so he was treated for that. And later he had a heart surgery in 1992. So I had an anxiety period, period of anxiety for us all. It's with the hope in god that we could deal with that time. We hear of surgery, [we] will be so scared. It will be filled with anxiety. But that time we kneel down and pray and through prayer we get hope. And we know that it's all designed by god and god will take care of this. So with that hope if you go straight, we can be helpful to the patient also and to the children also. (Sita)

> When I have anxiety I would always do meditation. Try to concentrate on god's name or read some religious books. This [is] the way, even now I do the same thing. That's the great help I have. To believe in god and he is the great helper. No one can help you than him. (Kabita)

Rita, who admitted suffering from "battered women syndrome," shared her coping experience:

> You see, my husband was doing some black magic. You know those black magic, what [people] call "mantra tantra," all those things. Because his mantra tantra is one thing and another was, I wasn't [experiencing] depression at that time. I didn't know how many medications I was taking. But my faith kept me going. It is my faith. I do prayer. I trust in the Lord, in Jesus. I pray and get some strength from that. Yaa it has given me inner strength to fight.

ii. *Prayer and Worship Remove Isolation*: Besides solving personal crises, prayer or reading religious books discourages self-centeredness and a tendency towards isolation (Koenig et al., 1988). From a traditional Indian perspective, prayer assists elders to prepare for a comfortable ending of the life cycle (Tilak, 1989). This belief system is demonstrated in Sumita's discussion of coping with loneliness, a common aspect of old age (Butler et al., 1998; Hooyman & Kiyak, 2002). Sumita emphasized that in old age elders should spend more time performing religious activities, rather than asking for more material resources, which may bring further pain.

> My mother is reading lots and lots of slokas. They feel [near] the end of the life [they should spend] more time thinking about god, you know, [and think about] what was the purpose of life rather than asking for more comforts and more entertainment and all. [So] it is the prayer, a lot of prayer. Prayer is a good therapy, for depression, for loneliness and for grief. But of course assuming they are religious. If they are not, that doesn't help. Nobody else can impose it on them. Like I can't tell you if you are not religious, "Go pray, you will get over it."

Mita corroborates this attitude:

> [If you are] Lonely, then take god's name. It is you who have to do something. If you are lonely, take god's name; anxiety, take god's name; depressed, then take god's name.

iii. *Religious Dialogue Heightens Spiritual Identity.* In addition to personal and private prayer, worship or pujas, some participants mentioned the practice of group faith activities. According to these individuals, involvement in group religious activities may also serve to encourage or discourage certain personality traits. For example, a few women in this study indicated that religious group activities have given them structural guidelines for dealing with life transition. Geeta explained that, in addition to her social activities, she is a member of a spiritual society to combat possible old age crises and to have a happy life. She thinks that by becoming a member of this "Vedanta Society" and actively participating in religious dialogue, she has established her "spiritual identity":

> Well, I am spiritually connected with god for so many years of my life. I'll say from 1987 on. So at least thirteen years that I have been involved. So we have Vedanta philosophy. We meet with Vedanta group on every Sunday morning, and that is a very big part of my life. So ultimately if both of you, husband and wife, feel that you have a firm connection with the ultimate spirituality, god, you can define it in any way. I am not

> narrow in my religious thinking. It's spiritual rather than a particular narrow part of religion or god. So if you are spiritually connected you are totally connected. Then you don't feel isolated at all. That's my firm belief. My parents came from a very highly spiritually believing family. So did I. So ultimately I think if you establish your spiritual identity, you will feel very, very connected with the whole world. That's the way I have combated that part of my life. Loneliness or whatever, I think all these terms are interconnected. I don't think one exist without the other.

iv. Prayer Meetings Provide Mental Strength. While several Hindu participants reported being members of a religious society or association, the Christian participants indicated that they meet on a regular basis in one of their homes for prayer. Like their Hindu, Sikh and Muslim elderly counterparts, these women think that participating in such spiritual activity has given them the mental power to reflect positively on life events and feel connected with the everyday world. Sita said:

> This is not [the] end of life. God is there. With great hope if you spend your day, everyday it's a kind of a medication. And trust in god, and faith and meditation, prayer and meditation; all will give us encouragement and mental strength to deal with this problem.

Babita confided in this interview:

> [We Indian women] our needs are very limited and also very different. Of course, we go out for a movie or out for dinner. [That is] once in a blue moon, but not like western people, you know. Then we go to church, wherever there is worship, or somebody come that is priest or something, I will go and attend that. I like to hear. I go everywhere [i.e.] Sai Baba's talk. Everywhere I go, I have no restriction. Some lectures I like to listen to, you know. Before I didn't have [the] chance because I was busy working. And [on the] weekend, I am busy cooking for the week and cleaning. Now I have more time. That is why I said I am enjoying my life now more.

Sumita further explained how group prayers can help an individual to escape grief, gain spiritual strength, and get better:

> Yaa! Gita [Hindu religious book] or even just saying Vishnu sahasranama [taking thousand times the name of Lord Vishnu], you know what that is. Like little tassels, and they are all just reciting verses or reading. If you don't know, just read it. The new ones [spiritual clubs] give them books. It is just like the bhajans here in the temple. So the bhajan groups here are good too. Like they have Satay Sai Baba's bhajan group, and the temple too. They sing on Tuesdays, every Tuesday. So you get to go there and then you forget your grief at [that] point and then slowly you get better.

v. Religious Movies Remove Loneliness and Isolation. Two participants explicitly mentioned religious movies as another external resource against sadness and loneliness. Anita, who did not consider herself too religious, commented that to avoid unpleasant circumstances, many elderly EIIW engage in activities that usually accompany daily traditions:

> Help other families. Some of them do pujas. There are many things to do. They read some books, fiction to cope. Or maybe, if they are ultra religious, then some religious books and so on. That's basically what they do. They also watch religious movies.

Wanita stated that, because many elderly EIIW are lonely, to remove this problem and maintain control over their inner self they engage in certain activities:

> Sometimes do gardening, put [in] the garden, digging, that sort of things. Or they may be just watching video like *Ramayana* or *Mahabharata* [Hindu mythological stories] or read holy books.

"Faith in God Gives Such a Relief that One Can Maintain One's Self Worth":

The nexus to the above religious (or dharmic) coping process is another frequently mentioned religious moral known as "faith in god." Faith in a cosmic power has made EIIW's life event crisis prevention activities more significant (Sandhya, 1994; Shirali, 1998). Therefore, unlike data reported in other cross-cultural mental distress coping literature, neither alcohol consumption, drug use nor smoking were mentioned as possible coping resources for this group. Vinita's analysis of elderly EIIW's coping with the struggles of life suggests that these women do not use alcohol as a coping resource:

> Medication, I don't know. I know my friends, nobody likes to take medication, especially for depression and stuff. They won't drink [to relieve stress]. I have hardly ever seen our people [women] doing this.

Instead, all participants, whether religiously-oriented or not, believe that by placing faith in god a person can achieve or maintain self worth, maximize control over the inner self, and prevent actual mental distress. Reflecting on this blended religious, cultural and psychological strategy, Bonita indicated:

> First is faith, because you have to hold on to something, right? You cannot live life without holding on to somebody and god is the only thing. What is god? I don't know. Nobody has seen god. Whatever it is Krishna or Jesus or Mohammad or whatever it is, you have to hold to something. Whatever religion it is and that gives you strength. That gives you such a

relief that you can overcome anything.

Punita adds:

> Grief can stay forever for me. I am that type. But when you see them [children] happy, then you say they are happy. Grief is because [you ask] "Why did it happen to our family?" Then again you go to your religion, your god. So we have to bear with it, accept it. We trust god and religion and hope something good will come out of it. Most of our women, even though they are lonely and all that, they go for their religious faith which keeps them going.

Sabita suggested that it is integral to worship to "remove" any pain:

> Yaa, worship for them [family and children], that is the main thing. Yaa! Always. That is first thing to do for something. You pray to god to make them happy. Whatever is happened make [my] son happy like that. You always do, very, very true. God give you answer. And when you pray to god also, you feel better inside. That's what I told you, remember. If your heart [is] true and clear, yaa! My husband says, "God always tell me we will not be long time trouble. God telling me in front of me."

Jeeta believes that EIIW depend on god to tolerate pain:

> I think they [elderly EIIW] depend on god. They always pray to give [them] inner strength to control. [For example, they say] "I don't want my family [to] die." You care for your children… [you don't want to see them] suffer.

Mita suggested that taking god's name keeps one's heart "happy":

> See, when you take god's name in your heart, then you can't think of [bad things]. All the time you take god's name, even when you are waking up, taking shower, eating, etc. So your heart much be happy. You won't have time to think.

In addition to the perceived positive psychological return from using "god's name" during crisis, participants who had personally encountered fatal accidents, cancer or heart surgeries felt that they were resilient in the face of these life-threatening events because of their strong faith in god and their routine spiritual practices. Kunita recalled her experience in a family car accident when she lost her four-and-a-half-year-old daughter but not her husband:

> I believe in Hinduism. I believe [since] I was a little girl. I always prayed god, "Mata" [female deity]. And I believe [in god] because [when] I was six years old, I started prayer. I was a young girl and [I prayed to god] I won't be a widow. Doctor said "How come? He is dead already. What do

you mean you won't be a widow?" I said "No. He [is] going to live and he is going to suffer. That is life." And he got better, one month after the accident.

Having illustrated the constructive role of faith in god in preventing her from suffering from the indignities of widowhood (Sandhya, 1994; Davar, 1999), Kunita goes on to explain how she rehabilitated herself from emotional depression caused by her domineering mother-in-law in later life:

> Yaa! When I am praying, I tell god. I am very close to god. I can see things. Good things or bad things. I said [to god], "You have choice [to make], you take me or take her." I always do that. I see myself first, then her [mother-in-law]. Because I told god, "You take me. If you don't want to take me, take her. It is your choice. I give to you this choice."

Rita shared her own belief:

> I do prayer. I trust in the Lord, in Jesus. I pray and get some strength from that. Yaa! It has given me inner strength to fight.

Clearly the participants not only perceive support from god, but some believe that because of their spiritual dedication and actions they are very close to god. This feeling of spiritual closeness appears to motivate them not to neglect prayer or meditation while seeking medical attention. As demonstrated, prayer not only helps these women protect their emotional, mental and physical self and prevent the development of stress related-diseases, but displays their self-worth in "coping capacity" (Davar, 1999). So the integration of spirituality and medical treatment can be interpreted as a collective measure used by the participants to reduce uncertainty and provide greater control over otherwise life threatening situations. Babita, whose husband underwent triple bypass surgery, explained that for all practical purposes faith in god helped her not to live with anxiety:

> Yaa! I talked to my friends. When we go to the church they give us moral support and their prayer helped us too. Not only my prayer, their prayer also. And all our friends [were] also praying, and they gave all the positive thinking, and they were saying, "With this new medical technologies the operation will be successful." And my children were around me. They were here, they were helping me. My daughter drove to the hospital that day. My son came to [the] hospital. And we had the priest, our priest [from India] at that time. He also visited us and came to the hospital before the surgery. While he was admitted also he [the priest] came there. All these helped me a lot. We had letters from the relatives in India, from

> my brothers and my brothers-in-law. They all helped us. But we cannot live on anxiety. That will cause the heart problem. So we have to be happy about everything that is happening, but we have to be very cautious about our health too.

Sita also remarked on how to construct moral strength using faith:

> Through prayer and meditation and by reading the bible and scripture [you can deal with problems such as anxiety]. First we have to have hope. We have to, when you are a Christian. In the Christian world, they all have to believe in god. With the belief in god, we have to submit ourselves to god. By submitting to god means that you are listening and obeying the spirit of god. Then with that knowledge you have to enlighten yourself by the Bible. Then you get more knowledge about god, and the spirit and forgiveness, all those good qualities. Those will help us to have great moral strength.

This diverse group of participants also shared with me many anecdotes suggesting that practicing religious activities such as prayer or worship does not necessarily mean one has to go to a religious institution or a spiritual leader. Instead, there is a strong belief among this group that prayer, worship, meditation and/or yoga can be practiced even at home and by individuals themselves, alone or in groups. Moreover, they seemed to think that for spiritual strength, home is one of the tangible religious institutions. So when participants talked about prayer, all openly mentioned praying at home and within themselves.

Nevertheless, the interviews indicate that participants were not completely distant from organized religion, religious artifacts or their symbolic significance. For instance, for all Hindu participants, prayer took place not only in their home but also in their prayer room with shrines (see Figure 10). Sumita mentioned her prayer room when speaking of coping with "temporary distress":

> Like I said, prayer is a good therapy for practical [purposes] or any kind of situation. We have a prayer room downstairs. I just go down and sit there. And I do meditation. I learnt that. You can come down and see our prayer room today. It is [an] unusually big one. I don't think every house has that big prayer room. But the basic idea is [that] prayer is the healer.

Christian, Muslim and Sikh participants indicated having religious posters, literature, decorations or ornaments in their homes, symbolizing their religious values. Most were quite aware of the psychological significance on their personal self, tradition

and cultural identity. Therefore, it was occasionally mentioned that even in recovery from mental distress, any sign and symbol of god in the house is of great importance to them.

"Coping with Distress Means Going to a Religious Institution": Another popular dharmic coping resource mentioned in the participants' interviews is attending religious institutions. Not all participants attended religious institutions on a regular basis, yet they seem to describe that activity as an intrinsic part of healing resources. Moreover, there was a pervasive sense among the participants that these institutions provide a physical space (Dossa, 1994) to elderly immigrants not only for spiritual but also for social, cultural and wellness practices (Schreiber et al., 2000).

Figure 9. A Sikh elderly immigrant woman participating in prayer at home in Edmonton, 2000.

Figure 10. A Hindu elderly immigrant woman participating in prayer at home in Edmonton, 2000.

In the spiritual context, several participants mentioned that religious institutions seem to have the power to make people forget about their personal, social and health concerns. Wanita, for example, described her understanding of Hindus' participation in their religious institution, the temple:

> [Our elderly women] go to temple because temple is good for depression people, you know. My husband, Saturday and Sunday if busy [we don't go]. Now I go to the temple, listen to prabachan [spiritual discourse], pandit [the priest] will tell them. He says very good prabachan. Listen to bhajan [spiritual song], sing bhajan, [you will] feel better, you know. And you forget about the problems you have. Temple is very good. Our priest is very nice. People sing there bhajan and so on. Nowadays, older people are coming more than before.

Similarly, Sumita said that temple is a good place to relieve problems:

> If you go to a temple or whatever is your religious belief … Again, I think going to temple, praying is a big help. And that's one way of dealing [with old age problems such as loneliness], like my mother.

In addition to worship and healing, some participants go to their respective religious organizations for spiritual guidance. Kabita admitted that although many older adults go to religious places to relieve stressful life experiences, she regularly visits the temple for spiritual guidance and self-observation:

> I go there for his [the priest's] guidance, you know. So that I can [relearn] what I read here at home, then I can follow. It is all about atma nirikhyan [self observation or introspection] we call it.

Amita claimed that, although she is not "institutionally religious," she believes that through her mother, now over 75, she fulfills her religious moral act for personal wellbeing:

> I encourage my mother to go to Sikh temple. Even though I am not an institutionally religious person, but when my mother goes there I kind of feel she is an extension of me. She is doing my part and also she is meeting people of her age. So she feels not only part of the family but part of the community as well.

Amita described the practical, cultural-based resources that are provided at the temple for devotees' positive emotional security, and the role and status of organized religion for her own personal spiritual wellbeing:

> They have sometimes meetings, some religious festivities. And every Sunday somebody gives a lecture; there are bhajans. There are functions where somebody gives free dinners for all those are there. This they give together, you know. They talk together, socializing. But this happens every Sunday. Then otherwise some religious functions. On auspicious days they do pujas [prayer]. I am not religious. I don't go, but whenever I am needed I go. See, we are not all that very orthodox people. I believe in Hinduism, but I don't believe in these extra rituals and spending unnecessary time and money on this. We are from Maharastra. On this Ganapati festival we give free lunch and peace; all together we practice bhajans and at least two or four hours we are there. At least once a year we go to the temple.

Organized religion is also considered to provide "spirit" to elders to overcome their problems and regain a strong inner self. Geeta explained one way to battle negativity and preserve a healthy self:

> Become socially connected. Go to the temple. I am not saying that in a very restricted way, [but I am] saying that temples mean spirit. Spirit world is [a] different thing. It's an energy that you bring with you that you have created in your mind. Cultivate it. You might be staying in the temple and lacking it. I don't equate that necessarily. So what I am saying is: you try it yourself. Ultimately you are your own saviour. Try yourself to see the examples in society that have strength, that have that peace, and emulate it. I have done that always in my life. So that's to me, from a younger age that was the way to conquer jealousy, for instance. Jealousy is part of everybody's life. How do you deal with it? You internalize it. You think about it. Why do you feel inadequate because there is somebody who is stronger than you? Do you feel inadequate? Then try to emulate them, try to set them in your life as an example.

Besides spiritual guidance, many also found peace and friendship in organized religion. Mita, who goes to the Jamat Khana every day, stated:

> All the time I go to Jamat Khana. It starts at 4:00 am and whoever wants to come can come. Evenings also, whoever can come they come. There we have a big gathering. We meet together. That is why we don't feel that we didn't see each other for a long time. Yes, if there is time then we briefly talk. But they will ask, "Why didn't you come yesterday?" Other than that we don't talk about anything else. And we don't go to anybody's house.
>
> In Jamat Khana, nobody tells me they have stress. Jamat Khana is such that you don't get time to talk anything else. You pray and then you go home. In the church, we don't talk about these things. We plan everything in the church. We have lots of seniors program, like picnic. Once a month they do barbecue [for] seniors. In picnic we go and eat. Music program and dandia dance [stick dance], and other dances. Then at 2:00 pm we

> come home. We have very good seniors programs. Convention takes place in Butterdome. We go there. Our Jamat Khana has buses. North Jamat Khana has three buses. South Jamat Khana has three buses. West Jamat Khana has two buses. We don't have [only] one Jamat Khana.

It is clear that religious organizations are not only the central place for prayer and attainment of peace; many participants go there for socialization and exchange of stories. In so doing, they seem to break their isolation, anxiety and feeling of loneliness. Therefore, traditional religious institutions may function as wellness centres for many older immigrant women. Jeeta somewhat confirms this thesis based on her unobtrusive observation and interpretation:

> Some people go to their organizational things like churches. I am being a Christian … I am just saying this Church [her Orthodox Syrian Christian Church]. Church, if you are a church believer. So you go to church more often if you can and then probably they pray and solve these problems [i.e. anxiety, loneliness or depression]. That is probably an outlet for them to pray. To go to the church and maybe there you meet some people, if you have same age group people. Because we have seen in our church too that when you have some mothers here [in Canada] and there is another mother or two or three people that same age group that they always socialize with them. They have something in common to talk [about], you know. I have seen three, four mothers when they were here. Even only when [they] meet once a week, they cling together. Maybe they share some of their feelings.

Clearly, for the participants the philosophy of "dharma" is more significant than just being institutionally religious. Most participants believe that spirituality has high power, helping them to forget internal pain even without the support of organized religion. Most seem to use various approaches in practicing spirituality to reduce the possibility of mental distress. For instance, one strategy appears to be the integration of Indian dharmic philosophy into the elderly women's everyday living. In fact, many mentioned that this practical strategy is critical for them to retain a state of balance or equilibrium in their emotional, mental and physical self.

Acceptance of Fate and Action (Karma)

Karma is a concept not only found in the Indian theory of life stages (Tilak, 1989; Chakravarthi, 1995) or in Hindu philosophers' discourse, but in all East Indian persons' everyday talk, regardless of their location, age, sex and religion (Guglani et al., 2000).

Karma refers to an individual's activities of the past and present and their impact on the future lived world, known as *samsara* in Sanskrit (Lamb, 2000, p. 116). Indian psychoanalyists such as Kakar (1982) and Tilak (1989) view karma as *act*. Shirali (1998), an Indian feminist, describes karma as *karmic self*. Regardless of how they define the term, scholars see karma as a valuable psychological resource and strength, to justify life's challenges. In Canada, Naidoo (1985) and other social psychologists in their South Asian feminist studies more commonly equate karma with concepts such as "fate" (*bhagya*), meaning destiny where an individual has no control over circumstances. Nevertheless, both terms bear similar psychological characteristics. They give an individual mental power to face challenges and maintain a healthy self. So karma is not only the "faceless" and "voiceless" (Shirali, 1998, p. 66) emotional self but is strongly connected to the mental and physical self.

In this study, the participants were very much involved in daily activities to combat perceived stressors and their coping activities were significantly influenced by the philosophy of karma. Participants used the moral law of karma to provide multiple explanations as to why they don't experience mental distress despite many changes in their lives in later years. For example, several women suggested that "change" was a natural and expected part of the life course; others believe that because they are still performing their social duties (see *grhasta* and *dharma* sections above), they don't experience mental distress. Some questioned their fate because of present crisis, but felt that they must face it to bring their situation under their control and not be victim of it. In describing her ongoing personal, family and professional crises, Sunita explained the consequence of negative events if not acted upon:

> You have to adjust yourself in that environment and circumstance. Whatever and whenever it comes, you have to face it. That's life, and whatever is in your karma it will come. But if it is not in your karma, then it won't. But if you don't face it, then you end up with death.

Neeta conveyed the strength of the theory of karma and described how a person can use it to maintain worth, respect and dignity, and at the same time reduce suffering. Neeta showed the close link between fate and action and its positive impact on inner self:

> Acceptance [accept such circumstances]. This is where the philosophy [comes] to your aid. You accept, "It's okay, this is what my fate is. I got to

> live with it." And probably they might turn to spirituality. The level of spirituality is directly proportional to the resulting detachment and acceptance. They [EIIW] turn to some solace, seeking solace from wherever it comes. And easiest thing without having to involve other people [is spirituality]... Well, once you emerged [immersed] yourself to acceptance, [this] takes you to the end. You seek solace in spirituality. After a while you become completely, you emerge [immerse] yourself in spirituality and then detachment comes. Attachment, acceptance transforms into detachment. It doesn't hurt any more.

Kabita explained with a big smile why she has never felt worthless because of the efforts she made to deal with the challenges of getting established in a new country:

> Because I have done some work which helped others to grow, and they appreciate it. So know I had a very hard time when I came here. Children were very small. I took the degree from the University. I looked after my children at the same time. I was working also. So they realized what their mother has done for them. I came all the way from India. I had to improve my qualification, so I had to go for degree. Though I was patting my son on my lap and here I was reading the book and getting ready for the exams. I told them that, and they realized that their mom has done so much. And they appreciate it so much. I had to clean the snow, shovel the snow because he was also taking education and improve his qualification. He [my husband] was going through law school. So I had to look after cleaning, look after my family, cooking. Then see that the sidewalks are clean so that mailman would not fall. Otherwise they will sue you, you know! So, I had to look after all these things and they know that all. So I feel that I am okay!

In contrast, Punita remembered how the combination of fate and her fear of failure made her not write a qualifying professional examination in Canada.

> Yes [laughing], that's what I deserve and that's my fate, I thought at one point. But my fate and also my mistake ... I should have had the courage to study and do the examination. God gives the fate. [But] the main thing is that it was my mistake [not writing the examination].

A few felt that depending *only* on fate is bad because it causes immense pain and suffering. One participant in particular sincerely believes that this "law of karma" is irrelevant for the 21st century world. This negative view resonates with several other scholars (Chakravarthi, 1995; Davar, 1999), who argue that fatalistic thinking makes some people passive, powerless and helpless. Leeta resists the philosophy of fate because of her knowledge about social problems and the risk it poses to EIIW's emotions, minds and bodies:

> Nothing fate, it is now you have to deal with it. Living in 21st century you have to deal with it. You know your husband drinks and [is] drunk lying in home. And if you think he is not doing [what he is supposed to do], then go to some doctors or get some help from therapists. And if he refused to do, then kick him out. Tell him to do his job, what he is supposed to do. That is my personal opinion.

Geeta discussed the combination of fate and action (i.e. karma) as a solution to mental distress. She described her philosophy that thinking about good actions can lead to good consequences (Wood, 2002, p. 43); her beliefs have led her to be actively involved in attempting to establish culturally specific facilities for South Asian elders in this community. She calls this community-oriented activity a "journey":

> Yes, you become a fighter in a social context. I came to that conference [South Asian Seniors Conference, November 2000] because I believe that if we unite, the government will hear our voice and our concern. So, on a social level you become a fighter. You do everything that you can in the health aspect. You try to achieve everything, and that will make you happy too, that part of your life that will achieve it. If you are capable, you are fighting for your rights that can give you happiness. Even if you are physically not capable, you have collected all the people. You are going for a cause. That will make you happy. Fight it at every level. Don't be [a] weak and submissive person. Acceptance does not mean that. So fight it as much as you can, fight it at every level so that [you fight] for our older people who aren't [financially secure]. So that is one way, active fighting.
>
> It's a journey. And if you are doing the journey the way you like to do it, then you have accomplished a lot. So I never try to get away if I feel that this is the goal. Physically, I'll be tired in doing it. I don't shirk it. I whole-heartedly plunge in it, involve all my friends with all their might to go towards it ... And that gives me immense satisfaction. Sometimes my mental energies are more than my physical energies and I am dragging my feet. But that's not the reason. To me, the day my mental energies are going to quit on me, then I will feel distressed.

Karma then is both acceptance of circumstances and an active response to deal with those circumstances. This emphasis on active living (Shephard, 1997) and "solution-oriented" (Sinha, 1994) behavior can also be found in the lifestyle and behavior change approach to health promotion, where health experts contend that change in behavior reduces risk factors for mental distress and other stress related disease and illness (Shephard, 1997; Denton et al., 1999).

Financial Support System (Artha) Increases Self Worth and Reduces the Chance of Experiencing Mental Distress:

> And they [the elderly] are financially independent. That's what increases their self worth [and] self-esteem. They are not afraid of younger people. Thanks to Canadian government that they are financially independent on their own. [Because of their financial base] the way I see it - a lot of doctors in the community make special effort to pay attention to them. Because I think it provides with their [doctor's] financial base. (Amita)

The participants believe that they have maintained distance from mental distress and enhanced their personal wellbeing through a secure financial support system, popularly known in India as "artha" (Tilak, 1989). "The Code of Manu, the most significant law book of ancient India, says power, status, learning, friends all follow the man who has attained [financial] well-being" (Chakravarti, 1995, p. 6). This section discusses how a financial support system helps the participants build their emotional, mental and physical wellbeing. In particular, how do their income (i.e. Canadian government's Old Age Security or OAS, Guaranteed Income Security or GIS, pension, savings and investments) and expenditures fit with their daily life in Canada? South Asian aging studies have repeatedly shown that elderly EIW's financial identity is invariably associated with living with family and children in later years (Boneham, 1989; Bagely, 1992; Burr, 1992; Guha, 1992; Dossa, 1994; Gurumurthy, 1998). In this study, however, the participants talked about being financially secure in Canada. They discussed their lack of financial stress and its link to strong inner self in terms of three broad points: financial status, personal control over financial condition, and expenditure on maintenance in old age.

Financial Status and Support System in Canada: In Canada, although elderly EIIW's income and employment record is poorer than that of Canadian-born women (Negi, 1996; Basavarajappa, 1998; Statistics Canada, 1999; Chard, 2000), in this study none of the participants mentioned having financial difficulties. Instead, they mentioned that their pensions, savings for their last days, investments on their children, real estate and stock market were enough to take care of them into very old age. They presented this type of financially settled identity because "economic identity" was not a common element of most participants' "entrance status" (Porter, 1965), referring to the type of job or investments they were holding upon arrival in Canada. In other words, though most

participants in this study are educated, they did not come as "pioneering females" (Isajiw, 1999, p. 88). A few immigrated to Canada under the independent class (see Table 1 in Chapter 4) with guaranteed employment; the majority immigrated under the assisted relative or family class category without a job.

Despite such diverse personal and background attributes, all participants discussed the positive contribution of the Canadian government's Old Age Security (OAS) and Guaranteed Income Security (GIS) in establishing their and other aged EIIW's healthy financial identity. The following comments reflect the variety of perceived personal benefits OAS provides, lessening the threat of mental distress among elderly EIIW:

> It's my projection that seniors are empowered, because they are financially independent [in Canada]. Many of these seniors never earned even a penny with their own hand in their young life. Of course they contributed a lot to the family wellbeing. But they were not wage earners. But now it gives them a great feeling that they are. The government is giving their entitlements. They are no less than anyone. People may be millionaires, but for them the $500 they get is as good as a million, because their money is their money. (Amita)

> I no talk like that "I no good" [and] "I am worthless." I [never] worked. My sons [work], but [I] no work. Now I am getting pension and I don't work. (Namita)

> Yes, I think probably [in India] there may not be financial security. But there are too many people to think of that [India has no State sponsored old age social security program]. Not here [Canada has], because if you have lived here ten years you get some money anyway. You get all kinds of old age security and all that. So that [finance] wouldn't be much of a problem. (Neeta)

Control Over Personal Financial Condition Shields Mental Distress:

Participants viewed person's financial condition as a potential major source of stress, a resource for avoiding mental distress, and a source for a feeling of worthiness. This positive feeling seems to grow when the elders maximize control over their inner self by being financially independent, especially when they distance their economic identity from their adult children and have the status of "income earner" (Desai, 1988). In this context, participants described control over their personal finances as critical because it brings financial independence, economic identity and self-esteem. It also allows them to

fulfill their "karmic" duty of "providing security to all, young and old" (Gurumurthy, 1998, p. 48). The participants' discussions about the relationship between financial condition and well-being touched upon personal income, housing and investments, savings, and employment.

i. *Personal Income Gives Financial Independence*: As most participants were retired, they emphasized that having an income was crucial to ease emotional strain in old age. Several commented on the close relationship between personal income and financial freedom. While discussing total household expenditure, Mita mentioned her financial independence and economic adjustment in Canada. However, this eleven-year resident is eagerly waiting to receive her OAS:

> I will get pension when I become 65. My husband gets [his pension]. His expense is spent here at home. Our rent is $500 [for] one bedroom. Then we have to pay for phone, light and grocery bill. And if you have a car then you have car expenses. We spent $1000 just like that. Our children said, "Don't worry. We will pay you whenever you need." They give us. They tell me that I will receive $800, not very much. When I will receive, then we together will make $1600. Then we will have some savings. Now we have no savings. We spent everything. I can't travel places. My friend, they both get this much and so they have gone for five months [travel].

Amita commented on how her mother, who immigrated at a later age with no personal income, achieved financial independence and freedom from her children for daily living:

> See, now other seniors have their own time, own money [meaning OAS]. They don't depend on us to buy them a ticket for travel. My mother has gone to India this November with my other sister. And although she doesn't want to go, I think she will enjoy it... The only thing is everyone here feels, "Why is she going?" Because she babysits all the people, she cooks for them, she sews for us... I think being involved, involvement is very important [for old people].

Unlike the others, Punita mentioned the danger of losing guaranteed income such as OAS in old age. Using the third voice, she raises the concerns about everyday living that arise in the minds of many immigrant aged, particularly the ill, the disabled, "lifetime homemakers" (McDaniel, 2002, p.141), people with no support group, the childless aged and people who have no children nearby:

> Many people are now beginning to feel, before they get old "What will happen to us?" If the government is supporting them, economics will not bother them so much. If they don't [there is a problem] because for their personal needs and all that, they need that [money]. I don't know from where they can get it. From their children or the government has a capacity to give that support, I don't know. But what do the government do when a person is in a nursing home? Do they still give them the OAS?

Punita goes on to describe fears about rising health care costs, reduction in personal income and loss of financial independence in family life and social relations:

> I know partly why they [older women] are saying all that, [because many are] diabetic. I am a diabetic too. [Some] have to take four times the monitoring of the blood sugar. And it's expensive, strips and all those things. So I spend away all that in that, and then what will happen if I retire also? [The fear many have] is, now I can work, I don't work, part time work, and then when I retire where am I going to get the money to give gift to the grandchildren?

Despite many changes made to Canada's old age program (McDonald, 1995; Oderkirk, 1996), most participants described OAS as their guaranteed cash source and an important resource for self esteem and prevention of mental distress. Therefore, all participants discussed their fear of losing control over OAS and financial independence (see Chapter Five).

ii. *Personal Income Gives Economic Identity*: Participants also described having income in old age as a key factor in retaining economic identity. All participants were knowledgeable about Canada's public-sponsored old age program. In fact, 12 reported receiving OAS, GIS and/or widow's pension. Nine were receiving not only OAS but also their occupational pension. Two had part-time employment and the rest were waiting to turn 65, to receive OAS and other old-age benefits.

About half of the participants spontaneously talked about how they manage their pension or savings. They were quite conscious of poverty (George, 1992; Sandhya, 1994; Dandekar, 1996; Gurumurthy, 1998; Kazemipur & Halli, 1999) and of the marginalized status and rank of economically dependent older women in the Indian patriarchal family system (Naidu & Sujatha, 1995; Thobani, 1999; Davar, 1999), both in India and Canada. So through their old age earnings and control over their personal finances, these female

elders seemed to believe that they had transformed the images of elderly EIW as helpless and powerless. Moreover, they have removed what Shirali (1998) defines as their "status-less existence" as aged women and achieved respect and dignity in the patriarchal and "youth-oriented" (Dandekar, 1996) Indian communities. With this positive attitude these participants claimed to be better off emotionally and mentally.

All occupational pensioners in this study also strongly argue that through personal income they have asserted not only their "economic identity" but their "economic status" (Sinha, 1994), like their male counterpart in the family. Thus they have expanded their caretaker role in the Indian household, both traditional and modern. In discussing socioeconomic status and lack of distress, Sita compared the financial freedom and social opportunities available to older EIW in India and Canada:

> Once you are in Canada, you are in a better position. Because here women are given more freedom; here people think that [a] woman is not a second class citizen. They have their own liberty. They can go to work. They can give [or] voice their opinion. These are good: positive ideas to nurture yourseleves too. Coming to the financial situation in a family, in India my father was dealing all the financial things. He was having the accounts and managing the money for the household and everything. Here, when both are working, both have their own deposits and accounts and the financial setup. So that way you have the liberty [of] doing your own management. How to spend money? How to save for the future? Like that, for your own needs. That is the financial part.

Sumita suggested that financial independence and personal space are very important for all elders' emotional wellbeing. Taking her independent and active lifestyle as an example of "healthy self," she stated:

> Yaa! Here independence means; "On their own." For in my case, I worked here. I have my pension or whatever. People who, even if your husband is dead, widows and so on who are on their own, they have their pension. They are financially independent. For that they don't depend on their sons or daughters to live with them. They can find what their interests are and stay engaged [and break their loneliness].

Amita talked about her own "personal space" and "independence":

> I value the time that I have just for myself. When I am only with myself, I am alone, but never lonely. I just love the various aspects of experiencing life because there is no limit to that. That makes me less dependent on travel, on friends, on money … So I really love and value my own time. I

> do hope all the people I see, I like to see them in my own image that they are happy. They have spent their life worthwhile. They have worked, they have experienced happy, they have experienced goings on in their life. I feel for once I have earned. I am not being proud, I just take pride and [feel] very grateful to god that I have this time. I worked all my life. I retired at the age of fifty-five. That's when my husband reached his retirement. He was sixty-five and my life looking back provided me with very useful sense of living my life.

iii. *Personal Wealth: Home Ownership Brings Economic Security*: Along with the old age pension, most women (n=18) mentioned that owning a home is another economic factor in successful old age. Participants explained home ownership as their cultural and karmic duty. Sunita talked about home ownership, indicating that she invested in landed property for the good of her children and the family:

> This is my home and they were living three months [her married son and his family]. He [husband] never used to give money at home. He was saying, "You have got enough money." He used to tell him, my son, "Tell her [his] mommy to buy you this gun, buy you that gun. That money wouldn't stay." But money will stay with me. Whatever the way I have got, I have got not that much that I haven't learned any subject on that. But I have got sense of spending very wisely. And I spend and buy things and wait that they are there. You ask me anything, I will give you. For the children's sake I got everything.

By applying the Indian maternal karmic explanation, Sunita was trying to show the patriarchal structure of the Indian household system, where gender and age are important factors in claiming power but also in achieved characteristics such as "economics" (Biswas, 1985; Naidu & Sujata, 1995; Yadava et al., 1997; Davar, 1999).

It may be appropriate to suggest further that the elders' valuing of home ownership is closely linked to avoidance of the strain of living in a joint household, improving the caring and nurturer role for positive familial relationships, and maximizing a happy and full life. This complex yet solution-oriented view of the participants points to their ability to resist the perceived ordeals of old age, particularly the lack of caregiving by adult children.

Several participants voiced their discontent with the behavior of adult Indian children towards their aged parents (as discussed in Chapter Five). Additionally, participants described situations in which they are still taking care of their adult children

to place them in a better situation, hoping they will take care of their old parents in later years, according to the "law of primogeniture" (Hooyman & Kiyak, 1999), "filial piety" (Wieland, 1991; Ujimoto, 1994) or "cultural duty" (Naidoo, 1992). As Vinita observes:

> I also think I am going to be dependent on my children. In India, we always see like this in our culture: we have our children, we help them in study, growing up, we spend all the money for the kids, and also for their future we keep money. For their safe future we keep money. So what their duty is when we get old, they are supposed to look after us. I am hoping they will do that.

Although the participants represent tremendous diversity and difference in terms of religion, language, caste, region, degree of acculturation, education and transcending values, they all described the erosion in Canada of the Indian cultural ideology of "children as old age insurance" (Pillai, 1985). Nevertheless, some revere this cultural practice[78] which is prevalent in India. For example, Kunita explained the feeling of "self-worth" children bring when they care for their aged parents:

> When I go to [see my son] he always say - "Mom, do you want money?" I say, "Vijay, you always say money, money. I have a lot." He say I suffer a lot that is why he wants I live comfortable. He doesn't want I cook, relax. Children are good.

iv. *Savings, Employment and Investments Bring Economic Self-Esteem*: Given the participants' rootedness in traditional Indian cultural morals, it is perhaps not surprising that all participants talked extensively about savings, employment and investments. The Indian philosophy of saving or saving enough embodies the concept that those who have not saved enough for their last days and invested in their children or landed property will have to continue to toil in life until the end (Gurumurthy, 1998). In Canada, despite the availability of guaranteed income and old age security, this karmic fear of suffering until death continues to influence the participants' attitudes and behavior very strongly. During her discussion about how to diminish suffering and pain in old age, Wanita explained how they save money:

> We never go for movies or, you know, hotels or bar or anything. Here people when they have money, they want to buy car, buy house. In India, if you make $10 you put $5 for saving and live with $5. Here they don't do that. Not our people. [They] are committed like that for the family's

[78] See Lee and Change (1995), Lamb (2000).

sake.

The participants explained that these additional financial activities cushion the stressful effect of economic status change in old age (Biswas, 1985; Pillai, 1985; Yadava et al., 1997; Gurumurthy, 1998).

A further example of the association between personal wealth and economic self-esteem is the participants' involvement in paid work. Many participants mentioned that having employment outside home has brought happiness, self satisfaction and economic self-esteem, most importantly when their income helped the family in upward social mobility. Employment was also mentioned as a way to cultivate economic self-esteem and self-worth, and to insulate them from disturbing old age experiences in a new country. For instance, Geeta admitted that though financial problems were not the reason for her to enter the labor market, holding a job gave her a sense of "usefulness":

> I will tell you in my case what happened. I did not need to go to work for financial reasons. But being so gregarious and outgoing and all that and being a career woman, I felt very good, even working beneath my capacities. My educational background is very high and I was teaching back home. But raising children for ten years, I did not get the job I could have. So I didn't mind working little bit in a lesser capacity. But working life satisfies my own usefulness part of my life. And then I didn't work so hard that I felt tired and robbing me of a lot of things that I could have done. So I started working part time for last thirteen years. So I could get everything personally. I also have my own investments, being an economist. Financially, I have my feet in the share market, real estate, in this and that, and I am doing all that. So my capabilities are fully utilized, I think, in that sense as well. Everybody has to find out for themselves what will make them happy. And doing all these things makes me happy.

A few participants reported a feeling of "economic worthiness" because in their early years they held jobs that helped their family and themselves to settle in a foreign land. Sabita[79] explained:

> After my marriage, I did twelve years job in London. I was working in the shop, baby's wear. And I studied six months. Every day when I come back from this shop, I used to go to classes by changing two buses, and learned English in England. I don't [didn't] know how to fill a form myself. If you

[79] This participant's husband used to work for an Indian bank in England on a foreign assignment. After residing there for an extended period, they returned to India and immigrated to Canada twelve years ago under family class reunification.

> don't know how to fill your form, then you can't get a job. For that I did six months study, to read and write English. And then I got job. And that way I have done a lot of thing. I use to learn [teach] ladies sewing, you know! My husband got one room for me and two machine[s], yaa. That I have done.

Lalita described her understanding of economic worthiness:

> In 1968 when we came, [within] four weeks or three weeks I got the job and I worked [for] thirty years in that job, in one job, in one place and in one office. So you know my lifestyle was different. I didn't go looking for job from one place to another, and interviewing and rejection and that and this, you know. No, I never feel worthless. So by god's grace I can do things and like health wise and little money wise and family wise, you know. You know, not that we have $100,000, but for daily living we are okay. Not that we are rich, rich, just to be comfortable to live.

Jeeta provides the final example of the association between "economic self-esteem" and a feeling of worthiness:

> I always felt that I am well worthy. I am employed. I am capable of handling my own affairs. And I was never a burden to anybody. I have financial security.

These excerpts illustrate the role of economic power in helping these women to maintain a healthy identity and a controlled inner self. For most participants, the feeling of worthiness does not rest on the type of job held but revolves around generational "arthic" advancement. The following section explains how expenditure on old age maintenance, the second feature of artha, prevents psychological distress.

Expenditure on Old Age Maintenance Helps Maintain Positive Internal Strength: Although actual data on the association between expenditure on old age maintenance and psychological distress among elderly EIIW is hard to come by, there was little disagreement among participants that driving, hiring outside help for caregiving, spending money on medical treatment, and using public transportation are important to avoid mental strain. In this study, a number of women mentioned that being able to drive reduced the feeling of loneliness, increased their sense of self-worth, and helped them continue their productive roles (Zhan, 1998, p. 32). Babita discussed one of "her major mistakes in life – [being] unable to drive." However, the following excerpt highlights the benefit of having money to overcome this barrier:

> I got my license, but he never encouraged me. The license is with me. The biggest mistake [I ever did]. That is the biggest, biggest mistake I made, you know. I can't depend on him. Now he is sitting [and] he can't drive [because of bypass surgery]. I am depending on my daughter or my friends. It is not nice to ask all the time. They have their own work. If he is sick, I can't drive him around or if I am sick he can't drive me around. We need both compatible for everything. That's the only mistake. But moneywise we both are earning, pension, you know. And we have some savings, the house is paid off. We are quite happy. Happy with whatever we have. Again [on] the brighter side, I think if anything happens to him, I don't have to take a driver's insurance or car insurance or anything. [With] that money, I take a taxi and go. That's what I am planning, you know. I can't depend on people all the time.

Kabita discussed her resistance to being dependent on family for minor needs and her use of external services to lessen the risk of emotional strain. Smiling, she explained her self-reliance:

> You see, I told you I don't want to depend on anybody. Otherwise my husband says, "She is staying home and I have to give her ride just because she has surgery." Then he gets cranky with me. Whether he is my husband or whatever, then they feel that way: "Now here she is bothering me." So I like to be on my own, and today I can go to the bus stop and get a ride. But normally it is very cold and very slippery, so this is very good service [DAT – Disabled Auto Transport] for me. They come to the door. They take me, and they see that the door is open and I am inside the house, and then they go.

A few spoke about their experience of loneliness, anxiety, helplessness and stress when sick. These negative experiences led some to look for a non-traditional caregiving support system, another marker of material wellbeing. Punita, who suffers from diabetes, admitted that she invested in "external help" to remove her feeling of helplessness because of her chronic illness and inability to drive:

> I am 74. I am sick, diabetic. I was sick the whole of last year. I had problems. I fractured my shoulder. So I still got along with my life. I get, of course, the help. I have a maid to cook and clean the place. I have a woman who comes and cooks once a week. The rest of the time, I do my own cooking and whatever. So it didn't or now it doesn't make me lie down or just brood over my past. Four months I was very sick. I never stayed myself all the time in bed or anything. I even went [out and] attended parties, which didn't stop me.

The discussion on hiring outside help demonstrates their financial ability and the mechanism they use to prevent mental distress. Geeta, who realizes that ill health is the

natural domain of old age, explained:

> So one day or the other [everybody will have to face ill health]. So we are trying to see around us how the older generation is coping with ill health. There are some people who are still living in their own houses. They have hired help and they feel more at ease. They are in the surrounding they are used to. They know their neighbors, they know their surroundings. They are used to a certain house. They are used to certain amenities. They are used to certain amount of area in their own movement. We are modeling ourselves, thinking on those lines. That is, when we get to that stage of old age we would like to continue living in our own house and hire some help. That's our thinking right now. Whether it will be practical or not depends.

This section has highlighted the positive role of a financial support system on the participants' mental wellbeing. All participants in the study hold a strong view that publicly funded OAS and GIS developed for the aged in Canada along with their personal economic resources have helped them claim economic independence, to ward off unwanted feelings and rely less on western medicine or mental health services, or even on family.

By Living Independently (Sannyasin) One Enjoys Authority and Rights: Independence

Among the activity-oriented approaches to maintain self-worth and avoid mental distress, living independently was the last dominant social strategy noted in the participants' talk. This social duty has multiple interpretations. According to the classical Indian theory of duties, "living independently" or *sannyasin* lifestyle, means disengagement from everyday life and entering the "renouncer" lifestyle with no attachment to family or material wellbeing -- *samsara* (Mays, 1983; Tilak, 1989; Chakravarti, 1995). In the modernization, urbanization and industrialization thesis of family type, the concept of living independently indicates moving away from "sociability" to "privacy" in family life (Bose, 1994; Laslett, 1995; Harven, 1996). Family sociologists and social psychologists have also argued it symbolizes an end to "family bond" and a closure to a "reciprocal sense of commitment, sharing, cooperation and intimacy" (Dizard & Gadlin, 1990; Bould, 1996). But in this study, the participants described living independently not entirely from a "Hindu life-cycle" perspective (Mays, 1983) of disengagement or "uncoupling" (Karp, 1994) from a relationship, or from modern thinking of privacy and detachment, but from an acculturation perspective of "not living with married children in the same household." Independent living also gives

EIIW complete authority, freedom and a physical environment in which to practice their Indian maternal caregiving responsibility.

Table 1 (Chapter 4) shows that participants on the whole lived in nuclear family arrangements. Nevertheless, the interview data revealed that all participants had cordial and normal relations with their children. In fact, the participants mentioned that their children have respect and love for them, and many live in close proximity, with daily contacts through visits or over the telephone. Several indicated that they make a couple of visits a year to see their children who live outside the city or country, and vice versa. A few write letters or email to their children and family members who live overseas. Punita explains:

> Sometimes I call and sometimes I [write]. Nowadays, there is no problem, we email, you see. Previously, before email, phone was [the main source of contact]. My husband was earning not so much to phone to Madras so much, every week. Somehow news gets from some other friends. Then we accept that, god forbid, if there is something wrong we will come to know. So that means everything is okay. So that's the satisfaction.

A majority of the participants reported at least one child living in the same city. Only one person has all her children residing with her and two have unmarried children living with them. Although there is a change in the family structure, a move away from the joint household to the seperate household, a majority of participants are certain that when need arises their children will take care of them. This strong feeling about familial care, it can be argued, is grounded in the Asian Indian model of "filial responsibility" (Desai, 1985; Kanbargi, 1985; Mehta, et al., 1995; Dandekar, 1996). Lalita, for instance, was certain about her children's emotional bond with their parents, which would lead them to undertake the cultural duty when need arises:

> God knows, we will see when the time comes. My children are there for help, I know that, for anything. They are there. But what I am saying [is] that I don't want them to quit their job and come and stay. I think most of our kids [would] do that. They will. They will take us, I know.

Participants mentioned a number of advantages of independent living arrangements. To explain the psychological benefits of this old-age living arrangement, several adapted the classical Indian viewpoint of "world-renunciation" (or sannyasin), not as a binary opposition to the householder (or world-oriented) stage, but as an extension of

it. Living independently should not be seen as a doctrine of detachment from ritual activities of a householder, but as acquiring personal space in which to find solace and contemplation, which is key to spiritual readiness for death (Tilak, 1989; Chakravarti, 1995; Lamb, 2000). Others described adopting this strategy because it gives them status, purpose and most important, a sense of achievement to live independently and be a role model for future generations. This theoretical explanation is somewhat similar to the model of "self development" in later life described by Novak (1997), to cope with role losses or decline in physical ability. On a practical level, some indicated that they consciously chose this living arrangement to avoid friction and misunderstanding with children, and to claim authority and freedom. A few felt they did not want to bother their children and preferred to make temporary visits and help children when asked. Although all came from a cultural background where living with a son is the tradition, only one talked about not living with married daughters because doing so is considered living outside the family. This trend may indicate that the Indian patriarchal ideology that sons are the first choice for old age caregiving, rather than daughters, is not critical among this group because of their situation, environment and acculturation/adaptation into Canadian society. A similar transformation in cultural values seems to be emerging in East Indian societies across the globe (Burr, 1992; Desai, 1992; Sandhya, 1994; Mehta et al., 1995; Dandekar, 1996; Mehta, 1998). Mita showed how she, a relatively conservative person, has become liberal in her thinking to avoid mental distress in old age:

> Both boys give [to] us, and our son-in-law also gives us money. We feel ashamed to take money from our daughter, because we have given away our daughter. But our son can give us because he is ours. Our daughter is [belongs to] somebody else [after marriage], and we can't take her money. But here [in Canada] there is nothing like that. Here I go to my daughter's house and stay there for two months. Here parents go and stay at their daughter's house. But in olden days we didn't stay at our daughter's house. We even didn't drink water in our daughter's house. He [my husband] used to say, "No, we can't drink our daughter's water. So let's take our own." I said, "What is this?" My father used to do all that. Now he [is] gone to god. He can't see what has happened.

Living Independently Reduces Familial Stress and Increases Independence and Respect: Much international and national social policy literature indicates that the joint household is a crucial social institution for people from Asian countries (Bagely, 1992;

Mahajan, 1992; Srivastava, 1994; Hu, 1995; Lee et al., 1995; Lee et al., 1996). It is also the clear preference for many aged East Indian men and women (Bagely, 1992; Guzder, 1992; Sinha, 1994; Kumar & Stanley, 1996; Lamb, 2000; Hooyman & Kiyak, 2002) for caregiving. In this study, however, most participants explained that, with changes in lifestyle, job conditions, geographic mobility, cultural values, health care and other circumstances, living in a joint household structure is not their preferred choice. Instead, living separately is seen as a better and safer way to maintain independence and respect and most of all to reduce misunderstanding, the key "familial stressor." Kabita explains that one of her major reasons for living in a nuclear family structure is to preserve "authority":

> I go to them [children], visit them, they come [and] visit me. And there is love when you are away from each other. They phone me and I talk to them. But if you live constantly with each other, then clashes come, quarrel, conflict comes. So I think I am really thankful to god that they are not with me. Everyday I go to my daughter. They are so happy with me. I help them. They help me also whenever time comes. I have no conflict with my children. You have love and sweetness also. And still you are away. Now in my house, I can do whatever I want. Some ladies say [that] "I have no authority [in my children's home] to even have a cup of tea on my own. When they tell I can have only one cup of tea a day [in a choked voice], it hurts."

Geeta stated how she is working to forestall dependency and suffering, which are inevitable with increased life expectancy and old age disease. This reasoning seems to imply not only a "healthy" and "controlled self" of an elderly EIIW, but also rejection of joint family or extended family as "caregiving units" (Hu, 1995) for reasons of personal, emotional and mental security:

> Well, I am concerned about dependency. I am independent-oriented. So I don't want that dependency. But I think eventually everybody will have to face it. We won't uproot ourselves. No, we are not thinking of running back home [India], because after so many years we are very comfortable. And we have established our roots, our children are here, and we feel we have friends in this society as well. And we feel very connected to Canadian society and Indians here. Even if I have an extended family, a very big one back home, who are waiting for me any time I want to visit... But there is a whole bunch of other aspects of that society that we are not used to living [with] on a daily basis.

The risk of mistreatment in a joint household arrangement and its negative impact on emotional, mental and physical self is brought out most strikingly by Kunita, who experienced daughter-in-law abuse in a joint household arrangement in Canada. From her perspective, living independently is "good":

> I want to help, want to do anything for you. I feel happy. But these days nobody cares that somebody is distressed. If money come, pension, old age pension, [which] everybody gets. They want to live alone because they want their own life. It is good to live alone, I think. Old people live alone, I think it is good. I experienced pain. If [you have] better children, [then live with children]. If the family is not good, [then live alone].

The chosen living arrangement of the participants represents an important aspect of coping practices in cross-cultural gerontology. In any society, making intergenerational linkage successful and reducing the risk of mental distress or suicide among aged women depend upon their social independence, respect and authority in the society they live in. In these societies, then, living arrangements determine the experience of mental distress. The association of independent living and mental distress and well-being among elderly EIIW deserves further investigation.

Accepting Adult Children's Independence: A number of participants talked not only about how they want independence but about how their adult children want their freedom. Many believe that their children are no longer very willing to live with their parents. The participants were sensitive to this change in the cultural value system and gave possible explanations for the differences. Most talked about differences from a comparative perspective. For instance, they continuously mentioned how their generation grew up primarily in a "non-pensioner" and "agrarian" culture (Biswas, 1985; Pillai, 1985; Bose, 1994; Lamb, 2000) where living with a son was the norm (Gurumurthy, 1998), whereas their children's generation are growing up in a culture where there is a universal social security system in place for all Canadians (Laing, 1992; McDaniel, 2000, 2002; McDonald, 2000). The repeated discussion about Canada's old age "safety net" indicates serious concern among the older generation relating to caregiving. Some believe that their children, particularly daughter-in-laws, are unwilling to act as caregivers to their aged parents-in-law, although doing so is a widely practiced custom in north and south India. Sabita describes this situation:

> I have a friend [who] always says, "Oh, I don't have anybody." She is all right with her son but his wife is not looking after her. Because she don't have husband, that is why she stay here [in Canada]. Her son called her here but [her daughter-in-law] doesn't like her. What can she do? [She said], "I don't want they stay separate. I will stay separate. Let them enjoy life."

Two additional reasons emerged for not choosing to reside in adult children's homes: the link between children's job stress and the burden of old age, and concerns about children's family situation. These reasons arose continuously in most participants' conversations, themes that were not anticipated from the review of literature which showed that a majority of aged EIIs live in joint households to help their adult children gain upward social mobility. However, this type of thinking demonstrates an essential characteristic of EIIW's maternal power, that they are thinking more about their children's happiness and convenience than about themselves. They believe that the tradition of the family lives on through the mothers' tolerance, ability to forgive, and willingness to sacrifice. Such attitudes, as many described, have helped them to prepare for a happy old age. For example, Lalita explained:

> I have never thought of living with my children, because it is bothersome for them. They have family and they are busy with their family, you know. But they don't mind, I know that. My youngest daughter always says, "I will look after you." But I don't want to create a botheration like that, you know. I know when they have time they will come. But [I will] not go and stay everyday. Even now I still go for two to three months to stay with my daughter. Three months always and two times a year I go. But every year, July and August, they come here with children [in] summer holidays. I know that they will. They do. But then, suppose you want to look after your mother, you have to quit your job. I don't want to bother anybody like that. I don't want to stay with anybody like that. So far, I can live alone and I like to have my own place.

CHAPTER SEVEN

CONCLUSION, IMPLICATIONS AND LIMITATIONS

> There is potential for all these things [anxiety, grief, loneliness, depression and mental distress] to happen. It hasn't happened so far. But these are the kind of things [that] would happen if proper environment is not created for them [aged EIIW] to face their last years. That is essential to start right now, to be thinking of it. (Geeta)

The changes in social, cultural, economic, lifestyle and health conditions of the aging population mean a rise in psychological and emotional problems in the future. Based on this integrative conceptualization of mental distress, the study "Constructing the Meaning of Mental Distress" is a modest attempt to understand elderly EIIW's perceptions of depression, anxiety, grief, loneliness, feeling of worthlessness, and mental distress. This study also examines how these perceptions influence the risk management process of the participants. The elderly EIIW were selected as research subjects because recently this group has experienced not only increasing life expectancy but also increased visibility in the Canadian aging population. However, this population has rarely been identified as a subject for social-psychiatric research. Therefore, consistent with the mandate of the symbolic interactionist perspective, this study analyzed the meaning of mental distress from the perspective of elderly EIIW. The research began with a series of questions, which the ensuing chapters explored by gradually moving from textual sources to interview data. The following discussion points out implications for sociological and cross-cultural gerontological research. This chapter will conclude by addressing the limitations of the study.

This qualitative study has revealed that for elderly EIIW mental distress is associated with "event-oriented problems" (circumstantial), "negative energy" and "life threatening" situations. Therefore, the elderly EIIW feel that it is critical that individuals "maximize control over the inner self" to prevent the experience of negativism, disability and death. This concern led the elders to elaborate on their risk management process. There is strong evidence in women's management strategies to support the thesis of Alcorn et al. (1998) that the role of culture changes according to the way one sees the world. Although culture guided East Indian women's conceptualization of mental distress

and its causes, it seems the integration of tradition, spiritual/faith, and to some extent acculturation experiences in the end leads these women to define culture as "moral medicine." The epistemic shift from culture as barrier to culture as moral medicine -- the aged immigrant women's rhetoric of "self control" -- depends upon having a strong historical, political, economic, cultural and social basis for assessing mental distress. The participants report using the feeling of self-worth to construct a healthy identity and strong inner self. Just as self-worth reflects a sense of self-esteem and being valued, so can a healthy identity contribute positively to self-confidence, which in turn influences the maintenance of strong emotional, mental and physical health.

In addition, the above major points, this research has thrown light on questions raised at the outset, questions which have principally arisen in the context of aged female ethnic minorities in Canada. First, it is evident that despite diversity in the sample subjects, the data show that participants conceptually converge in interpretation. The aged EIIW still define mental distress from a traditional Indian feminine perspective. One possible explanation is that all of them were born and raised to adulthood in India, where discussion of aged women's mental distress is noticeably absent. The little information available, however, romanticizes aged East Indian female mental distress (Shirali, 1998; Jamal, 1998). In Canada, though all the participants have been exposed to the term, most did not seem to consider mental distress a serious illness until it was connected to body or physical self, as for example in reduced life expectancy or chronic disability. Moreover, the participants described mental distress among EIIW as a product of personal attitude and behavior. The definition provided by the elders has not exclusively followed the western medical dichotomy of mind and body. Instead, they make a holistic East Indian interpretation, which includes emotion, mind and body as interdependent (Pert, 1997). At the same time these women believe that mental distress can be consciously controlled by both internal power and self-cultivation, particularly by changing individual attitudes and behavior. Because of such patterns of thinking, the participants usually did not feel a need to consult with professionals, traditional or western. This self-help explanatory model somewhat supports both the theory of difference and denial. Most importantly, it helps build a

positive image of aged EIIW's identity as strong, knowledgeable, wise and active ethnic women with no, or only temporary, psychological problems.

In addition, the study has shown how traditional Indian ideology, which primarily focuses on family and children, has helped these women to widen the sociocultural gaze to fit their personal and Canadian experiences. This epistemological base has assisted the participants in identifying new and emerging problems from everyday living, acculturation, and change in circumstances. Among the perceived causes of mental distress, the participants in this study identified issues related to loneliness, care giving, lack of economic control, leisure activities, widowhood, lack of personal space, lack of communication, death and dying, health-related stressors and moralistic reasons. The evidence here does support the "universalistic" position, in the sense of pointing to areas of commonality in the causal factors of mental distress offered by the participants. The data found something universal not only in possible stressors but also in the consequences of mental distress, including depression. However, no one mentioned suicide as a way to deal with suffering. Instead they thought suicide an inappropriate approach to dealing with problems.

Previous studies that examined psychological distress among visible minority aged women in the United States, for example, have shown a rise in suicide rate among Asian and Pacific Islanders. Researchers have explained this trend through theories of migration and culture (see Chapter 3). Here, however, the causal interpretation of aged immigrant mental distress goes beyond the history of migration and culture to include change in life course and weak internal locus of control. In contrast, practicing effective distress management strategies has helped the elderly EII women in this study to develop strong internal power so that they can be resilient to any life stressors and secure a valuable and prominent presence in the family and Canadian society.

In regards to theories of resilience, the research revealed that "staying busy" and carrying out "social-moral duties" were the two most important cultural ideological pillars on which the participants based their everyday risk management activities. It was also observed that the participants, by mixing the cosmology of values as found in

Indian tradition and religion, have developed five major activity-oriented themes, that is, the women mentioned the practical merits of being engaged in household affairs, spirituality, karmic duty, financial support, and living independently. From the participants' perspective, these daily activities and practices play an increasingly important part in the lives of ethnic minority women, particularly women born into a strong patriarchic and stratified culture. To most participants, an activity-oriented philosophy was a path to cultivating a sense of self worth and has allowed them to claim authority and autonomy over their lives. The participants believed that by gaining power and freedom they have not only maximized their internal strength, but also minimized their risk of mental distress. Despite changes in EIIW's household structure and economic activities, there has been little erosion of East Indian maternal caregivers' duties, only some modification in how they are practiced.

In other words, by creating new roles and maintaining traditional roles, the participants in this study tended to think themselves in the best possible situation to address life crises and achieve a full and happy old age. For this reason, it seems natural that they often reflected, upheld and reinforced some of the norms and values of Indian theories of "duty," "spirituality," and "patriarchy" which, in their younger days as wives or daughters, they had ignored or challenged. The interview data indicated that for all participants their cultural "roots" (Isajiw, 1999) function as a moral medicine against the "new day demon."

I. Implications for Caregivers, Policy Planners and Future Research:

A comprehensive conceptual examination of how elderly EIIW construct the meaning of mental distress has important implications for health care, cross-cultural gerontology, and society at large. Perhaps the most central of these implications relates to the consequences of mental distress. The information on consequences not only shows how important the issue is but also illustrates the high-risk personal and health concerns. Four broad issues were identified: loneliness, denial of pain, anxiety, and grief among elderly EII women.

This study indicates that, as more EIIW begin to age in Canada, erosion of the joint household arrangement, rise in old age ailments, lack of caregiving, and loss of financial support will likely have a significant negative effect on their emotional, mental and physical health. For example, the participants reported loneliness as the most important predictor of mental distress among older EIIW. No matter which individual was speaking and what was her educational, religious, linguistic, economic background and marital status, they all singled out loneliness as the most important causal factor of mental distress. Active involvement in identifying and establishing loneliness prevention measures to avoid mental distress is absolutely essential. These older women's voices and experiences raise questions about the effectiveness of the culturally sensitive health services established to this point in Canada. This finding supports Louie's (1998) contention that professional caregivers must be knowledgeable about diversity among aged immigrant subgroups and about their personal and health experiences.

It is important that this analysis not be construed to imply that elderly EIIW do not need any professional help, or that they are healthy people and should continue with their maternal/nurturing duties and maintain their tradition and culture. Instead, health researchers must engage closely with ethnic communities and give more emphasis to ethno-specific and comparative research. In the current changing population demography and sociopolitical environment, this type of information has become necessary in order to establish a client-friendly, community-based mental health service and to develop and maintain a risk-free environment for all elders.

Previously, no model systematically explains the risk management strategies and utilization patterns of mental health services of the EIIW target population. This study has established a phenomenological baseline that may aid social planners who are dealing with diagnostic, measurement, and service utilization analyses. The analysis also suggests important implications regarding the role of faith and spirituality in the risk management process. This research presents some important traditional and spiritual/faith practices of aged EIIW that help in both prevention and management of mental distress. The findings from this study may broaden the western health service provisions that seek to ameliorate the mental health of the sufferers, non-professional caregivers (non-PCGs), and professional caregivers (PCGs) in the multicultural aging society of Canada.

Finally, this study suggests several areas of research for future investigation. For example, studying the phenomenon of mental distress revealed that many participants encountered emotional problems in their lives, and also that they coped with problems by using culture as "moral medicine." This innovative coping process suggests that the experiences of non-institutionalized elderly EIIW will benefit future social and cross-cultural research. Exploring distress coping strategies in other populations may help to clarify the present model further and to bring a new critical posture to examining the mental distress experiences of any group in Canada.

Although this analysis has focused on older EIIW's response to mental distress, its findings may apply to other populations as well. For instance, under what other circumstances should we see "maximizing control over inner self" as a female or male response to distress? Evidence of females working to build inner strength is pronounced in conditions where women are uncertain about the outcome of certain events. These coping strategies become especially important under conditions where a person loses hope or fears social stigma, and when there is a high rate of resistance to becoming dependent on biomedical treatments. Therefore, the present analysis suggests further research on mental distress among minority aged men and women. Through more qualitative research, social planning based on participants' knowledge may increase the effectiveness of services for the aging.

II. Research Limitations

There are several limitations to this study. First, the analysis focused only on older EIIW's conversations. The reason for focusing exclusively on immigrant females is that they are a high-risk group for mental distress. It is difficult to say whether the social and personal resources of elderly EIIW such as living independently, spirituality, karmic role, financial support system, and caregiving role would act as distress preventive measures for other populations such as older EIIM (East Indian immigrant men) or other older South Asian women. Second, as has been reported in the literature, qualitative findings based on personal experiences, thought and knowledge would not apply to every concept and situation. For example, the perceived definitions, causes and consequences of non-clinical psychological problems may not extend to clinical psychological

disorders. Similarly, the coping process for clinical disorders possibly will be different. Third, the wording of the questions, and the method of data collection and analysis did not allow exploration beyond common psychological problems. Nevertheless, this analysis of the social construction of mental distress has permitted exploration of the causes, consequences, and risk management process of elderly EIIW.

The information presented throughout the study provides powerful evidence of the link between weak internal locus of control and life crisis that generates and deepens the experience of loneliness, grief, anxiety, feeling of worthlessness, depression and mental distress. In addition, this study has observed that tradition and Indian beliefs about an unhealthy self and fear of medical dependency have combined to force individuals consciously to adopt ingenious strategies for disease prevention and health promotion. Lack of understanding of these self-help prevention strategies practiced by visible minority aged women may hinder clinical intervention and increase the risk of prolonged hospitalization or higher death rates. In conclusion, this study has provided a new model for research into aging Third World women's mental health.

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APPENDIX A

Immigrant Population in Canada, by Place of Birth and Periods of Immigration 1961-1970, 1971-1980, 1981-1990 and 1991-2001.

Place of Birth	Total number of immigrants	Periods of immigration							
		61-70[a]	%	71-80[b]	%	81-90[c]	%	91-01[c]	%
Total for Canada	**5,448,480**	**745,560**	**100**	**936,275**	**100**	**1,041,500**	**100**	**1,830,680**	**100**
United States	237,920	46,880	6.2	62,835	6.7	41,965	4.0	51,435	2.8
Europe	**2,323,560**	**491,320**	**65.9**	**338,525**	**36.2**	**266,185**	**26.1**	**357,845**	**19.5**
United Kingdom	606,000	160,005	21.5	126,030	13.5	60,145	5.8	42,645	2.3
Other N.& W. Europe	494,825	86,820	11.6	56,345	6.0	45,595	4.4	57,235	3.1
Eastern Europe	471,365	36,595	4.9	30,055	3.2	104,825	10.6	164,465	9.0
Southern Europe	715,370	207,900	27.9	126,095	13.5	55,620	5.3	93,500	5.1
Asia	**1,989,185**	**90,415**	**12.2**	**312,050**	**33.4**	**491,725**	**47.2**	**1,066,230**	**58.2**
West-Central Asia & Middle East	285,585	13,360	1.8	29,675	3.2	75,885	7.3	162,220	8.9
East Asia	730,600	36,360	4.9	97,610	10.4	155,070	14.9	423,235	23.1
South-East Asia	469,105	14,095	1.9	107,445	11.5	159,660	15.3	185,665	10.1
Southern Asia	503,895	26,600	3.6	77,320	8.3	101,110	9.7	295,110	16.1
C. & S. America	304,650	17,155	2.3	62,925	6.7	102,655	9.9	116,005	6.3
Caribbean & Bermuda	294,050	42,740	5.7	91,475	9.8	68,840	6.6	84,005	4.6
Africa	282,600	23,830	3.2	54,655	5.8	59,710	5.7	139,770	7.6
Oceania & Other	52,525	8,870	1.2	13,910	1.5	10,415	1.0	15,380	0.8

[a] Pre-Multiculturalism Period.
[b] Multiculturalism Period.
[c] Post-Multiculturalism Period.

Source: Statistics Canada, 2003.

APPENDIX B

Constructing The Meaning of "Mental Distress" : Coping Strategies of Elderly East Indian Immigrant Women in Alberta.

Investigator: Manju P. Acharya, Department of Sociology, University of Alberta

Pre-Interview Invitation to Participants and Collection of Potential Names

My name is **Manju Acharya** and I am a doctoral student in the Department of Sociology at the University of Alberta. For my dissertation research I am interested in exploring **elderly East Indian immigrant women's understanding of some common problems such as grief, loneliness, worthlessness, anxiety, depression and distress.**

I have been given permission by the Ethics Committee of the University of Alberta to talk with aged immigrant women from India living in Edmonton Metropolitan area regarding the above problems. For this research project, I would like volunteer(s) who: was born in India, between the age 60 and 74 years; has lived in Canada for 10 years or more; and can converse in English. Each person may be interviewed two times, each lasting approximately one and half hours. The interviews will be tape-recorded, and take place at a time and location that is convenient for you.

The information that you give will be considered confidential and will be used in such a way as to protect anonymity. Your name will not be included on the tapes and written transcripts and you will not be identified in the dissertation or any publications of the study findings.

Although the information you will provide may not benefit you directly, it will hopefully benefit professional care givers who provide service to culturally different clients. If you are willing to participate then please give your name and telephone number to the director of your organization. I will contact you immediately after the receipt of the name to set a date, time and place for our interview. Thank you for participating in this research.

Yours sincerely

Manju P. Acharya
Principal Investigator
University of Alberta

Participant's Name----------

Telephone Number----------

P.S. If you choose to contact me directly, then my contact numbers are: 435-6194 (H) or 330-3325 (Mobile)

APPENDIX C

Constructing The Meaning of "Mental Distress" : Coping Strategies of Elderly East Indian Immigrant Women in Alberta.

Investigator: Manju P. Acharya, Department of Sociology. University of Alberta

Information for Ethics Review Committee

The data collection and processing procedures for the above study have been carefully designed to meet the University of Alberta Ethical Guidelines for Research involving Human Subjects.

No. 1: If research procedures can potentially lead to physical or mental harm for the subjects, the benefits of the research must significantly outweigh the risk.

The health and demographic questions to be asked of adult non-institutionalized subjects in this study (see attached questionnaire) are on topics which would not be expected to cause physical or mental harm to the subjects. The interview questions include self-reported definition of illness, utilization of health services, perceptions of mental and physical illness, and concerns relating to mental health service delivery.

No. 2: Participants must give fully informed and voluntary consent.

Written permission from all participants will be obtained to participate in the study. Respondents will be informed that they can refuse to answer any questions asked (refer to page 2 of the questionnaire). Subjects will be briefed that this study is part of my doctoral research in the department of sociology, University of Alberta. In addition, the subjects will be made aware of the purpose of the study, and the person they could contact if they wish to verify the legitimacy of the study.

No. 3: Participants must be guaranteed anonymity and their responses must be treated with confidentiality.

Subjects will be informed that their responses will be anonymous (i.e. no names will be requested). Once the interviews are completed in the designated households, the address and telephone numbers will be removed from the data set making it impossible to identify the persons interviewed. I will follow the University of Alberta's Ethics policies and confirm that all interview information remain confidential.

No. 4: Investigators must be knowledgeable about the potential risks.

The risks to human subjects participating in this study are not large (see No. 1 above). My thesis supervisor, and the thesis supervisory committee members have extensive experience in the area of health research dealing with human subjects.

No. 5: Individuals working for the principal investigator must be trained and competent.

During my M.A. thesis work in 1994-1995 at the University of Lethbridge, I carried out fieldwork, including in-depth interviews for a period of ten months. Through past fieldwork experience and employment at the Population Research Laboratory, Department of Sociology, I know the importance of administering questions in a standard, consistent manner and probing for sufficient information. I will also be supervised throughout by my thesis supervisor and committee members when needed.

APPENDIX D

Constructing The Meaning of "Mental Distress" : Coping Strategies of Elderly East Indian Immigrant Women in Alberta.

Investigator: Manju P. Acharya, Department of Sociology, University of Alberta

Interview Appointment

A. Telephone Introduction to Potential Participants

1. Hello, my name is **Manju Acharya** and I am a doctoral student in the Department of Sociology at the University of Alberta. For my dissertation research I am interested in exploring **elderly East Indian immigrant women's understanding of some common problems such as grief, loneliness, worthlessness, anxiety, depression and distress.**

2. Your name and telephone number was given to me by your association director, -- (Please read the name).

3. I have called xxx-xxxx. Is this correct? [The phone number is recorded in case there is a need to contact the respondent again.]

4. I would like to interview you. I'm hoping that you will agree to set a date, time and place for our interview. This interview will take from one and a half to 2 hours or less.

5. The information that you give will be considered confidential and will be used in such a way as to protect anonymity. Your name will not be included on the tapes and written transcripts and you will not be identified in the dissertation or any publications of the study findings. If you are willing to participate then you are free to not answer any specific question, and may withdraw from the study at any time. You are free to ask me questions regarding any aspect of the study.

6. May we now set a date and time for interview that is suitable for you.

Date: ----------.

Time: ----------.

Address: ----------.

APPENDIX E

Constructing The Meaning of "Mental Distress" : Coping Strategies of Elderly East Indian Immigrant Women in Alberta.

Investigator: Manju P. Acharya, Department of Sociology, University of Alberta

Informed Consent Form

I _____ know about the research project. I agree to participate as a volunteer in the above study. I am fully aware of my role and responsibility, and willing to co-operate with the investigator. I understand that I have the privilege to not answer any specific question, and can withdraw from the study any time, without penalty. I am also allowed to ask the researcher questions regarding any aspect of the study.

_____
Signature of Participant

_____
Date

_____
Investigator

APPENDIX F

Constructing The Meaning of "Mental Distress": Coping Strategies of Elderly East Indian Immigrant Women in Alberta.

Investigator: Manju P. Acharya, Department of Sociology, University of Alberta

Interview Guide and Questions

A. Signing of Consent Form (Appendix IV)

1. Before we start, I'd like to assure you that your participation is voluntary and that any information you provide will be kept confidential and anonymous. If there are any questions that you do not wish to answer, please feel free to point these out to me and I'll go on to the next question. You, of course, have the right to terminate the interview at any time. **(HAVE THE PARTICIPANT SIGN A CONSENT FORM).**

(TO ESTABLISH A CORDIAL RELATINSHP READ TO ALL PARTICIPANTS)

2. If you have any questions about the interview and the study, you may call my Supervisor Dr. Herbert C. Northcott (in Edmonton) **at 492-0479, between 9:00 a.m. and 4:30 p.m., for further information.**

B. POSSIBLE INTERVIEW QUESTIONS

SECTION I:

In our everyday lives we hear people talking about problems such as grief, loneliness, worthlessness, anxiety, depression and distress. In this interview, first I would like to ask you some questions about *grief, loneliness, feelings of worthlessness, anxiety, depression* and *distress*: 1) who suffers from these problems, 2) how do East Indian people behave towards people who are suffering from these problems, 3) and how do East Indian people deal with these issues. I would appreciate you frank and honest answers and please remember your responses will be kept confidential.

3. Can you please tell me what does "suffering from grief" mean to you? (Open-ended)

Possible Probing Questions:
-Who do you think suffer from grief?
-What do you think causes grief?
-What life events cause grief?
-How long do you think they suffer from grief?
-How East Indian women suffering from grief explain their problem?

4. How would you be able to recognize a person suffering from grief?

Possible Probing Questions:
-What are the symptoms?
-How do East Indian ladies feel about people who are experiencing grief?
-Why do you think they react that way towards people who are in grief?
-How does others reaction affect those people who are suffering from grief? (Look for both positive and negative).

5. How do East Indian ladies deal with grief?

Possible Probing Questions:
-Who do they turn to?
-Is there anybody a person who is suffering from grief will turn to?
-When do they turn to others for help?
-What medication do they use?
-Are there special ways to cope with grief? If there are, please describe them to me.
-What formal support a grieving person use?
Psychiatric/Ayurvedic/Medical/Other.
-What informal support do they use? Family/Friends/Religious leaders.

*****The same questions will be repeated with the other terms – loneliness, feeling of worthlessness, anxiety, depression and mental distress.*****

SECTION II

Finally, I would just like to ask a few questions about yourself

6. Will you please tell me which of the following age groups you belong to?

1. 60 -64 years
2. 65 - 69 years
3. 70 - 74 years

7. What is your marital status?

1. Never married (single)
2. Married and living with spouse
3. Common law relationship (opposite sex)
4. Living with partner (same sex)
5. Widowed
6. Divorced
7. Separated
0 No response

8. Do you live in a/an: **[DO NOT READ. MARK ONE ONLY]**

1. Detached House
2. Apartment
3. Duplex
4. Basement Suite
5. Other ---------- (Please specify).

9. Including yourself, how many people live together in your household? ------.

0. No response

10. In what year did you (first) immigrate to Canada? ----------.

11. Under which immigration category you were admitted into Canada?

Independent

Assisted Relative

Family Reunification

Refugee

12. How large was the community you came from?

1. City
2. Town
3. Village
4. No response

13. What is your religious affiliation?

3. Hindu
2. Islam
3. Christian
4. Buddhist
5. Sikh
6. Jain
7. Other _____(Please specify)
0. No response

14. What is the highest grade or level of education you have attended?

(DO NOT READ. MARK ONE ONLY.)

1. No schooling
2. Some Elementary (Grade 1-6)
3. Some Junior High School (Grade 7-9)

4. Completed Elementary (Grade 1-6)
5. Completed Junior High School (Grade 7-9)
6. Some Secondary/High School (Grades 10-12)
7. Completed Secondary/High School (Grades 10-12)
8. Some Community College, Technical College, CEGEP, or Nurse's Training
9. Completed Community College, Technical College, CEGEP, or Nurse's Training
10. Some University or Teacher's College
11. Completed University or Teacher's College
12. Post-Graduate (e.g. MSc, MA, PhD, MD)
0. No response

15. Are you currently working for pay?

1. Yes
2. No
0. No response

16. Do you drive?

1. Yes
2. No
0. No response

We have reached the end of our interview, and I would like to thank you very much for your time and your participation!